the Canadian Nurse

VOLUME 58 • NUMBER 3

MONTREAL

MARCH, 1962

HIGHLIGHTS

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THE CANADIAN NURSES' ASSOCIATION

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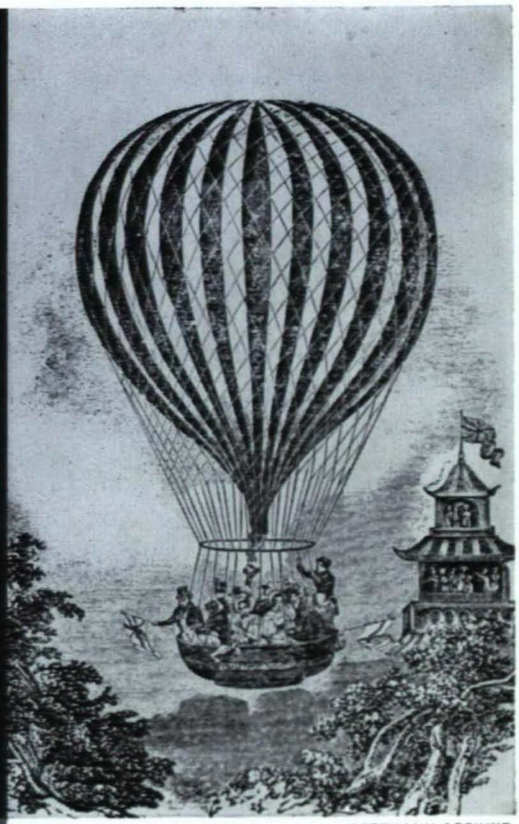

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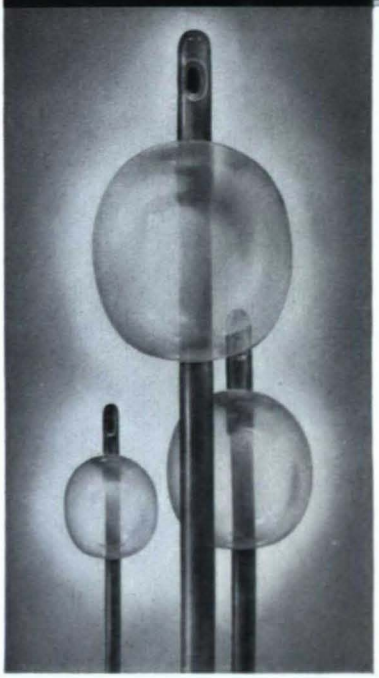

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AURORA ONTARIO

Between Ourselves

The last time the convention of the Canadian Nurses' Association was held in Vancouver — in 1950 — we were able to publish a wonderfully informative and interesting account of the lore of British Columbia written by DR. WILLARD E. IRELAND. Before we began our search for a comparable article for this year, we reread the original piece. It is still so appropriate that we wrote to Dr. Ireland and asked him to bring it up to date, so far as figures are concerned, so that we might share it with the many thousands of readers of this issue. If any of you can remember it from twelve years ago, we can only suggest that you refresh your memory by reading it again. It certainly merits re-reading. For those who were not even a part of the nursing scene at the half century mark, we promise you a real treat.

* * *

During the past few months, many nurses in every province have had an opportunity to become acquainted with GLENNA ROWSELL as she discussed varied aspects of the School of Nursing Improvement program. As our guest editor, Miss Rowsell brings us all up to the minute on the progress that has been made so far and the planning for the future.

* * *

It was noted in this column last September that our provincially-appointed Editorial Advisors were soon to meet with the Journal Board and the editorial staff. They had been asked previously to secure, so far as they could, reader comment, criticisms and questions in respect to the *Journal*. We spent a very profitable day and a half with the advisors and, since then, have carefully reviewed all of the suggestions they brought to us. It was decided at our meeting that some of the most frequently asked questions should be answered here, since all 65,000 of our readers may be interested in the answers. We will welcome your further comments at any time, either as letters for "Random Comments" or again through the advisors.

We were truly appreciative of the many very pleasant remarks reported by our advisors. Someone had asked the question, "Why don't they publish unpleasant or highly critical letters in the *Journal*?" We do, if and when we receive them, providing the letter carries a subscribers' signature. Unsigned letters are read, then deposited in the best place for that kind of communication — the W.P.B. We welcome your letters, especially those that give us your ideas in respect to the topics discussed in the various issues.

One editorial advisor told us she had been asked why we took so long, sometimes, to publish news of the death of some of our colleagues. Almost always it is because no one thinks to write and tell us about it. Mimeographed forms for this kind of report have been distributed in every province. If your chapter or alumnae association has none, please get in touch with the editorial advisor for your province who has the supply. Or you may simply write us all of the facts yourself. We have been told many, many times that you do want the *Journal* to pay this final tribute to Canadian nurses.

The question that appeared most frequently in our advisors' reports concerned what was termed "the lag" between the time an article was accepted by the *Journal* and the date when it finally appears in print. Why does this delay occur?

A number of factors enter into the preparation of every issue of the *Journal*. There are some sections that are "must-runs," as, for example, the "World of Nursing," "Pharmaceuticals," this column. The balance of the editorial content for every issue is decided by the editors many months in advance. The articles in this issue, for instance, were selected in early October, 1961. That was six months ago. Since this is the regular pattern we have to follow, it is obvious that all but specially requested material that may come to our office this month, in all probability will not be published until next autumn.

Why do we have to work so far in advance? The first and most important reason is because we try to have essentially similar material in both of the languages in which our *Journal* is published. Good translations, either from French to English or vice versa, take time — and we do have to meet our printer's deadlines!

Finally, some nurses have asked "Why are there so few pictures?" Glance through this issue. We've used a good many of them this month. All too few articles lend themselves to photographs.

What other questions have you?

THE CANADIAN NURSE

VOLUME 58 **NUMBER 3**

MARCH 1962

Executive Director and Editor: Margaret E. Kerr, M.A., R.N.
Associate Editor: Jean E. MacGregor, B.N., R.N.
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Circulation Manager: **Winnifred MacLean**

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Administration—One daily, or as prescribed.

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Indications—In the prevention and treatment of constipation. Its fecal softening action is indicated wherever hard stools are a problem: anorectal surgery, geriatrics, pediatrics, immobilized patients, during pregnancy, and to prevent straining in cardiac and hypertensive patients.

Description—Each red capsule contains: 240 mg. calcium bis (dioctyl sulfosuccinate); each orange capsule contains 50 mg.

Administration—*Adults:* 1-2 240 mg. capsules daily. *Children:* 1-3 50 mg. capsules daily.

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Indications—For non-specific treatment of all forms of cough and bronchial congestion occurring during bronchitis, tracheobronchitis, rhinitis, and cough following the common cold.

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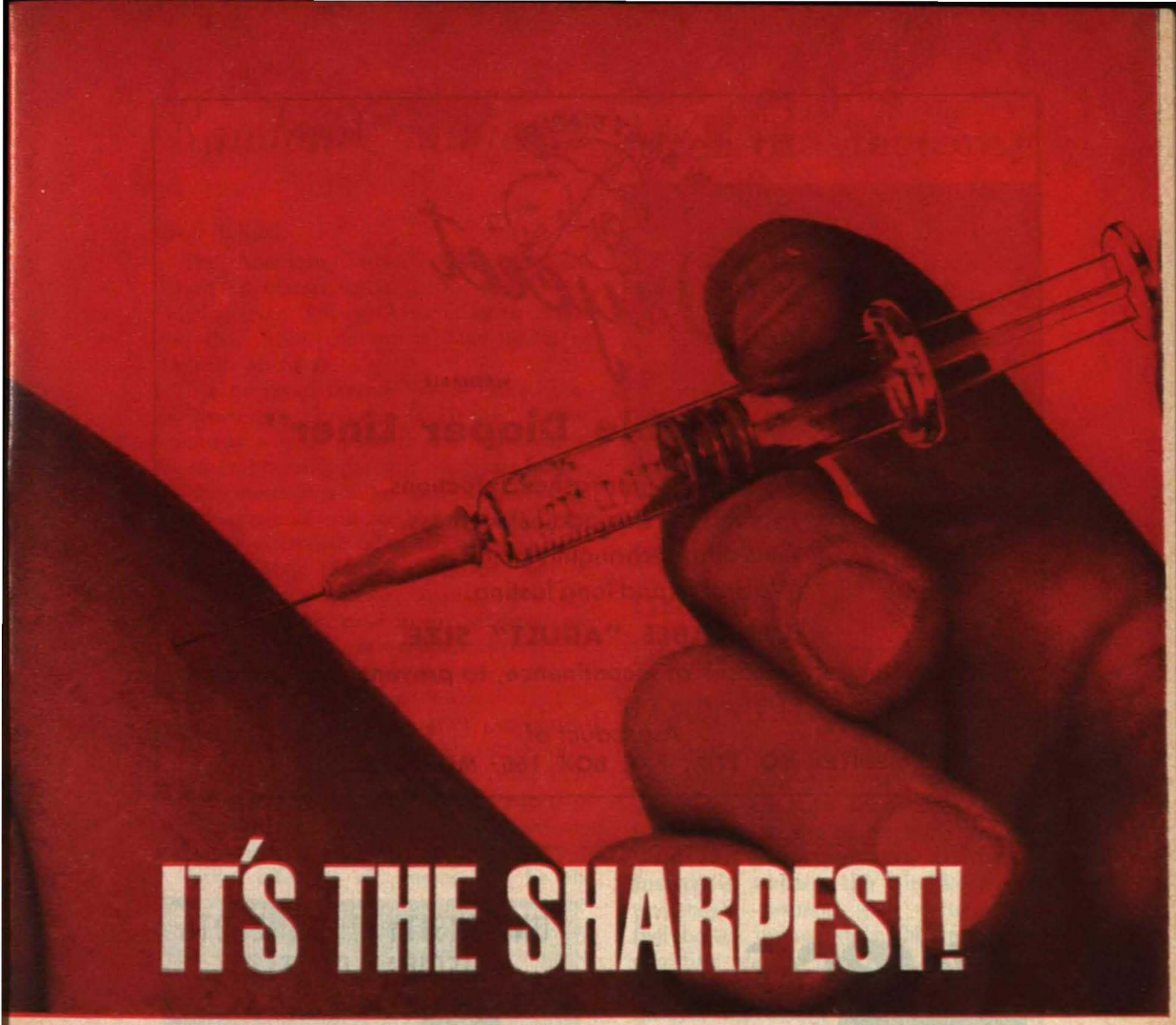
Administration—*Under 2 years:* as determined by the physician. *2-4 years:* 1 tsp. 2-4 times daily; *5-12 years:* 2 tsp., 2-4 times daily; *over 12 years:* 3 tsp., 2-4 times daily.

Precautions—Exercise caution if used simultaneously with barbiturates and narcotics, as methdilazine HCl, is known to potentiate the action of CNS depressants. Contraindicated in the presence of severe hypertension, glaucoma and prostatic hypertrophy.

The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.



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Random Comments

Dear Editor:

The American Nurses' Association has issued an official invitation to members of the Canadian Nurses' Association to attend the 1962 ANA convention, May 14-18, in Detroit, Michigan.

The theme of the meeting is "Excellence in Nursing — Progress in Health." Major emphasis will be given to the improvement of clinical nursing practice. A special feature of the meeting will be two sessions of 20 simultaneous clinical meetings scheduled for Tuesday afternoon, May 15 and Thursday morning, May 17. These sessions will be centred on the specific nursing skills and knowledge nurses need in giving direct patient care. Clinical, preventive, rehabilitative and family aspects of nursing care problems will be presented through research reports, panel discussions, case histories, demonstrations of new nursing techniques, etc. Several sessions will deal with new concepts in nurse-patient relationships and the effects of new treatment methods, electronic and automated devices on them.

Issues affecting all nurses will be the topics of three general program meetings: economic and general welfare; allied nursing personnel; standards of professional nursing practice. Nursing in national defence and nursing research are the topics of other sessions.

Registration for CNA members is the same as for ANA members: $6.00 for one day; $15.00 for the week. Canadian nurses must present proof of membership in CNA for 1962.

For more information and reservation forms write to: Convention Unit, American Nurses' Association, 10 Columbus Circle, New York 19, N.Y.

Dear Editor:

Calstok Sheepskin, supplier of hospital sheepskins, is now making a pelt sample available to all hospital and rest home authorities and nurses. Descriptive literature and case history examples of sheepskin users are also available on request to:

Calstock Sheepskin,
P.O. Box 3103,
San Francisco 19, Calif.

Dear Editor:

As a result of the efforts of three Los

Over 287,000 people of all ages took part in Canadian Red Cross water safety services and projects last year.

Angeles librarians, a five-year index of 13 journals in nursing and related fields is available. The first annual supplement, which will be ready early this year, will add 18 more journals to the original 13 indexed. The price for the 1956-1960 index is $20. Orders, accompanied by cheques should be sent to:

Mildred Grandbois, Librarian,
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Box 871, Glendale 5,
California.

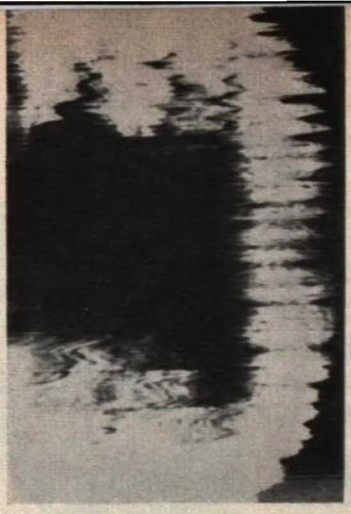
Dear Editor:

Our recently completed Directory of Rehabilitation Services for Saskatchewan has aroused considerable interest beyond the boundaries of the province. It is a type of ready reference manual that many agencies and individuals interested in rehabilitation would like to see compiled for their own part of Canada.

It gives detailed information about the many organizations in the rehabilitation field, while the listings and numerous cross references simplify the process of finding out just what services are available and how they may be procured. Besides listing agencies and services, the directory gives other valuable related facts and information on hearing aids, orthopedic appliances, etc.

To partly defray costs we are making a nominal charge of fifty cents for single copies, which may be obtained from:

(Mrs.) May Neal,
Co-ordinating Council on Rehabilitation,
416 Health and Welfare Building,
Regina, Saskatchewan.



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BUSCOPAN effectively blocks smooth muscle spasm wherever it occurs in the gastrointestinal, biliary, urinary, and genital tracts. Its spasmolytic action is potent and selective. With a minimum of side effects, BUSCOPAN decreases hypermotility... relieves pain.[1-8]

RESULTS OF TREATMENT WITH BUSCOPAN IN VARIOUS SPASTIC CONDITIONS

Condition	Number of Cases	Good to Excellent	Fair to Satisfactory	Poor	Side Effects Reported
Genitourinary Disorders[2,3,5]	163	135	21	7	None
Gastric and Duodenal Ulcer; Gastrointestinal Tract Spasm[4,8]	56	36	11	9	None
Biliary Disorders[3,6]	38	28	4	6	None
Operative Procedures[8]	10	7	2	1	None
Totals	267	206	38	23	None

Because of its superior antispasmodic properties, BUSCOPAN provides valuable adjunctive therapy in x-ray investigations where spasm may prevent proper diagnosis. It is also useful pre- and postoperatively, in procedures involving the gastrointestinal and genitourinary tracts, and in obstetric conditions characterized by spasm.

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References:

1. Lössl, H. J.: *München. med. Wchnschr.* (supp.) 94:653, 1952.
2. Birkner, E.: *Wien med. Wchnschr.* 102:893, 1952.
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7. Schmidt, J.: *Medizinische* 21:1293, 1952.
8. Block, A.: *Fortschr. Med.* 71:202, 1953.

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*Niedelman, M. L. and Bleier, A.; Jour. Ped., 37:5, 762, Nov. 1950
Fischer, C. C. and Lipschutz, A.; Am. Jour. Dis. Child, 89:5, 596, May 1955
Benson, R. A., et al: Arch. Ped., 73:250 - 8, July 1956

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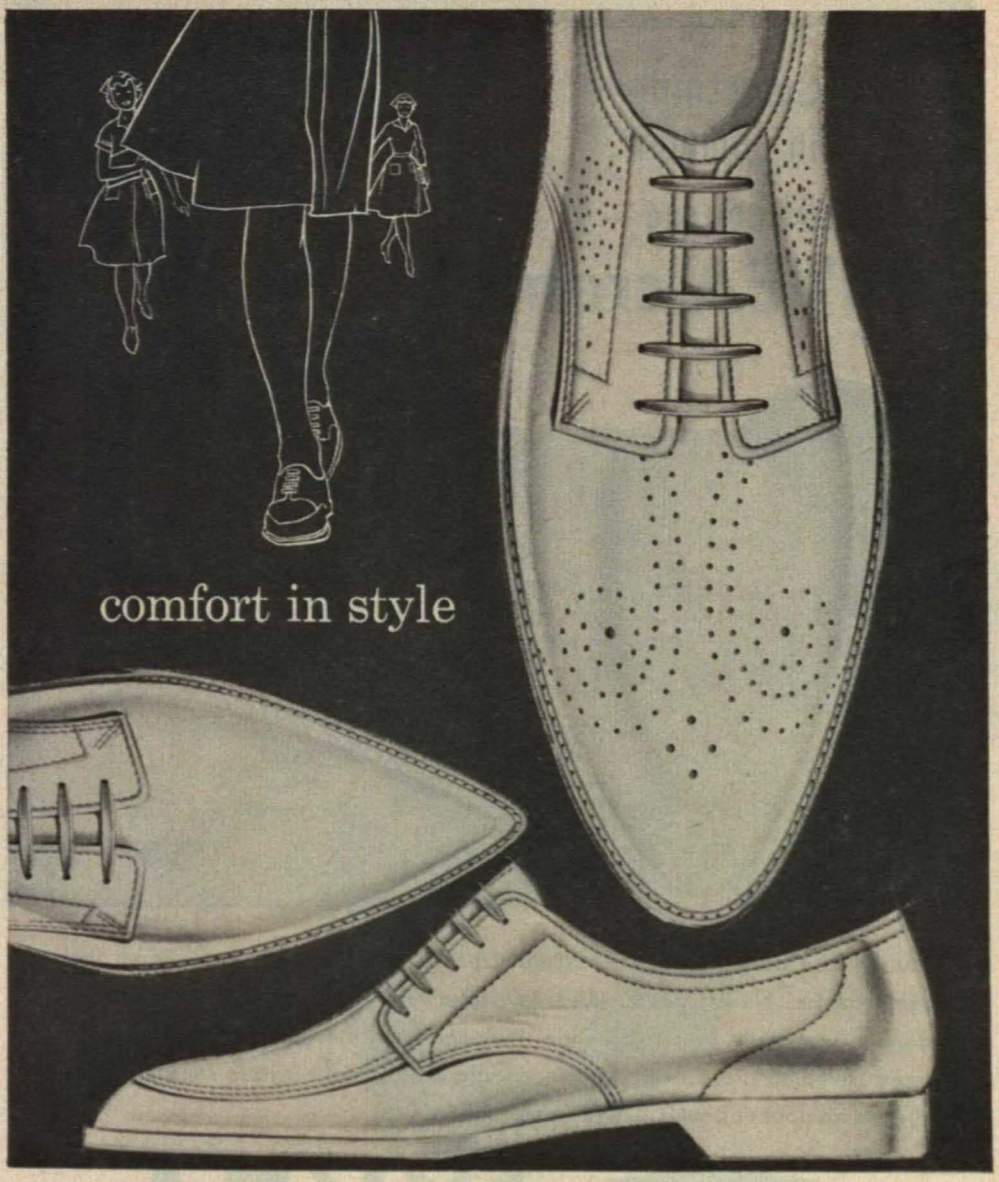

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*Bogash, R. C.; DeLa Chapelle, N.; Sowinski, R., and Downes, D.: Disposable Type Vials for Adding Medications to Large Volume Parenterals, Am. J. Hosp. Pharm. 17:104 (Feb.) 1960.

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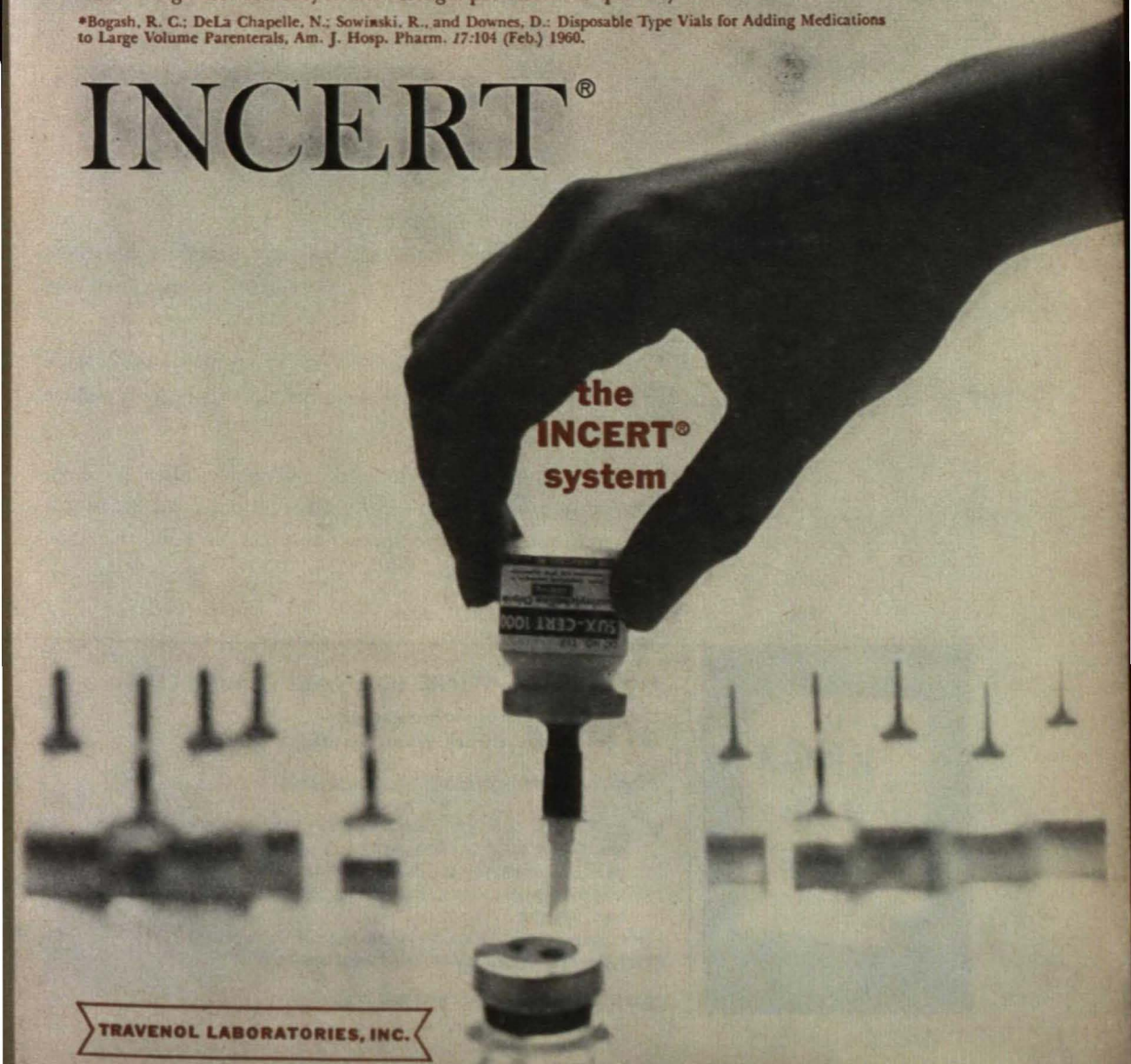

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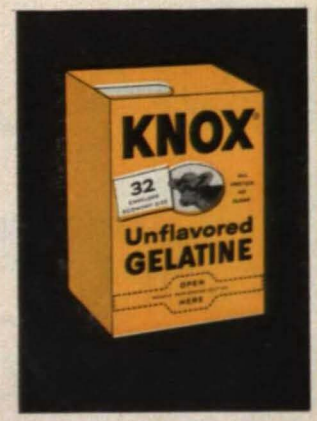

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- ☐ 1. Rosenberg, S., Oster, K.A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September, 1957.
- ☐ 2. Derzavis, J.L. and Mulinos, M.G.: Med. Ann. D.C. XXX:133, March, 1961.
- ☐ 3. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July, 1957.
- ☐ 4. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March, 1955.
- ☐ 5. Tyson, T.L.: J. Invest. Dermat. 14:323, May, 1950.

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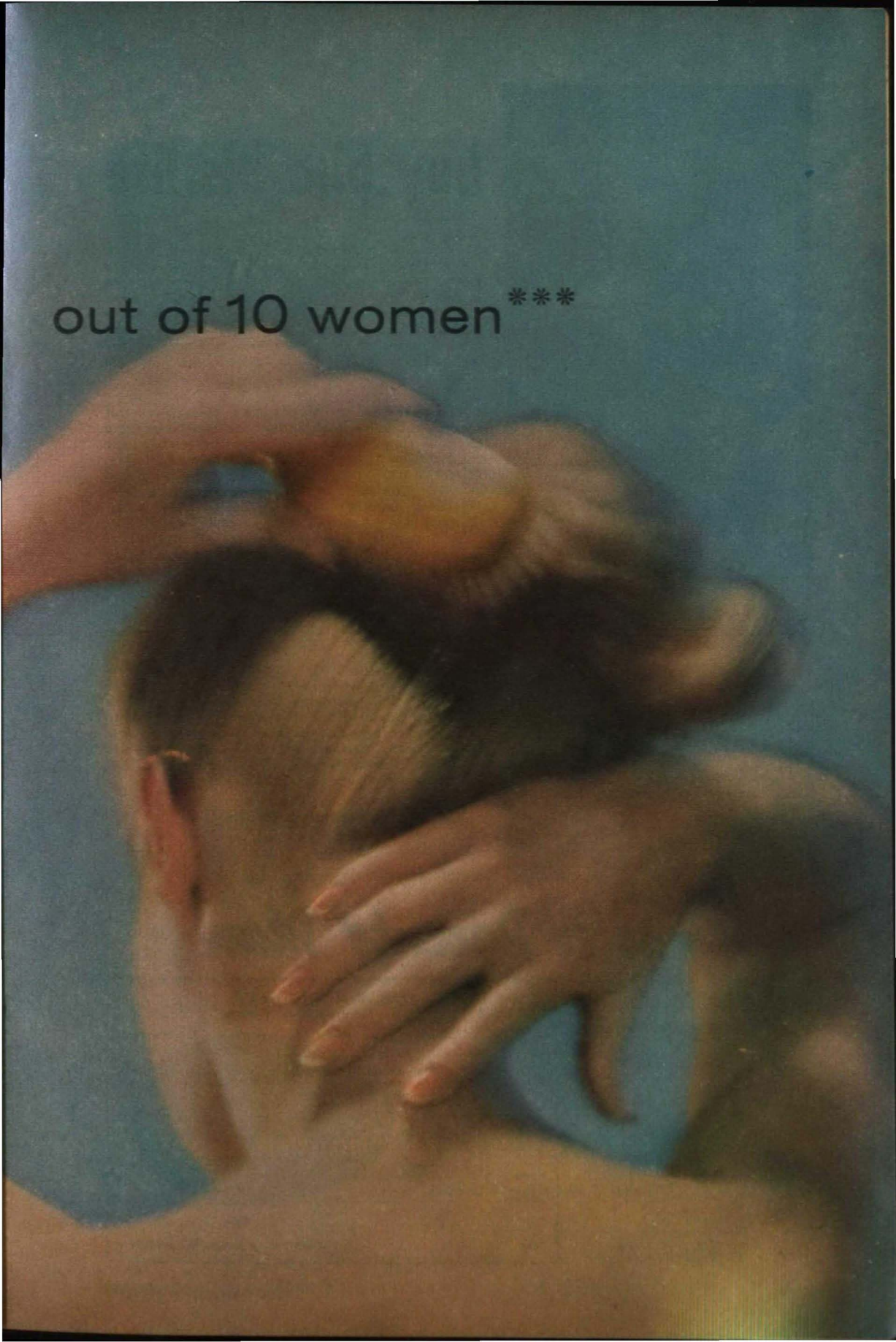
out of 10 women***

buy him his life

Tran Dien, Vietnamese, age 5. Father ill. Cannot work. Mother tea-picker. Losing sight. Unable to choose good leaves from bad. Lost job. Five children in family. "Home" is thatch hut. Earthen floors. Dien has almost no clothes. No trousers. Shown in photo with borrowed pants for sake of dignity. No decent food. Nothing. Poverty extreme. Parents despairing for children. Help to Dien means help to entire family. Need acute.

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Plan is a non-political, non-profit, non-sectarian, government-approved independent relief organization. Financial statements are filed with the Montreal Department of Social Welfare and the Toronto Board of Trade, *and are available on request because we are proud of the handling of our funds.* Plan helps children in France, Greece, Italy, South Korea, Viet Nam, Hong Kong and the Philippines.

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FOSTER PARENTS' PLAN, Dept. CN-3-1-62
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If possible sex.....age.....nationality.....

I will pay $15 a month for one year or more ($180 per year). Payments will be made monthly ( ), quarterly ( ), semi-annually ( ), yearly ( ).

I enclose herewith my first payment $.....

B. I cannot "adopt" a child, but I would like to help a child by contributing $.....

Name .....

Address .....

City ..... Prov. .....

Date ..... Contributions income tax deductible

THE PARENTERALS PAGE NUMBER 5

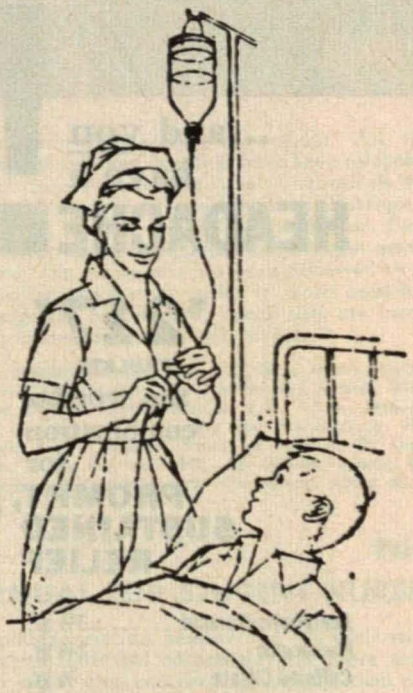
Blue plate special ...from a bottle

It's not enough simply to return our patient from surgery in "good shape." We must keep him that way.

The surgical patient has a special problem of nutrition. During the period of stress surrounding surgery, he needs a high level of nutrition. Yet frequently this is a time when he's unable to eat, or to assimilate what he does eat.

Thus almost without exception, the surgeon will order *parenteral* feeding after major surgery. In fact, if it weren't for parenteral feeding, many of today's major operations would require a much longer convalescence period.

Most of the needs for good nutrition are available. You can give carbohydrates in the form of sugar solutions. With intravenous alcohol, you provide extra calories for quick energy. With amino acid solutions, you supply protein. Vitamins and electrolytes fill other important requirements.



Of course, surgical patients aren't alone. There's hardly a branch of medicine in which parenteral feeding doesn't play a part in hastening recovery or saving lives.

...and you have a

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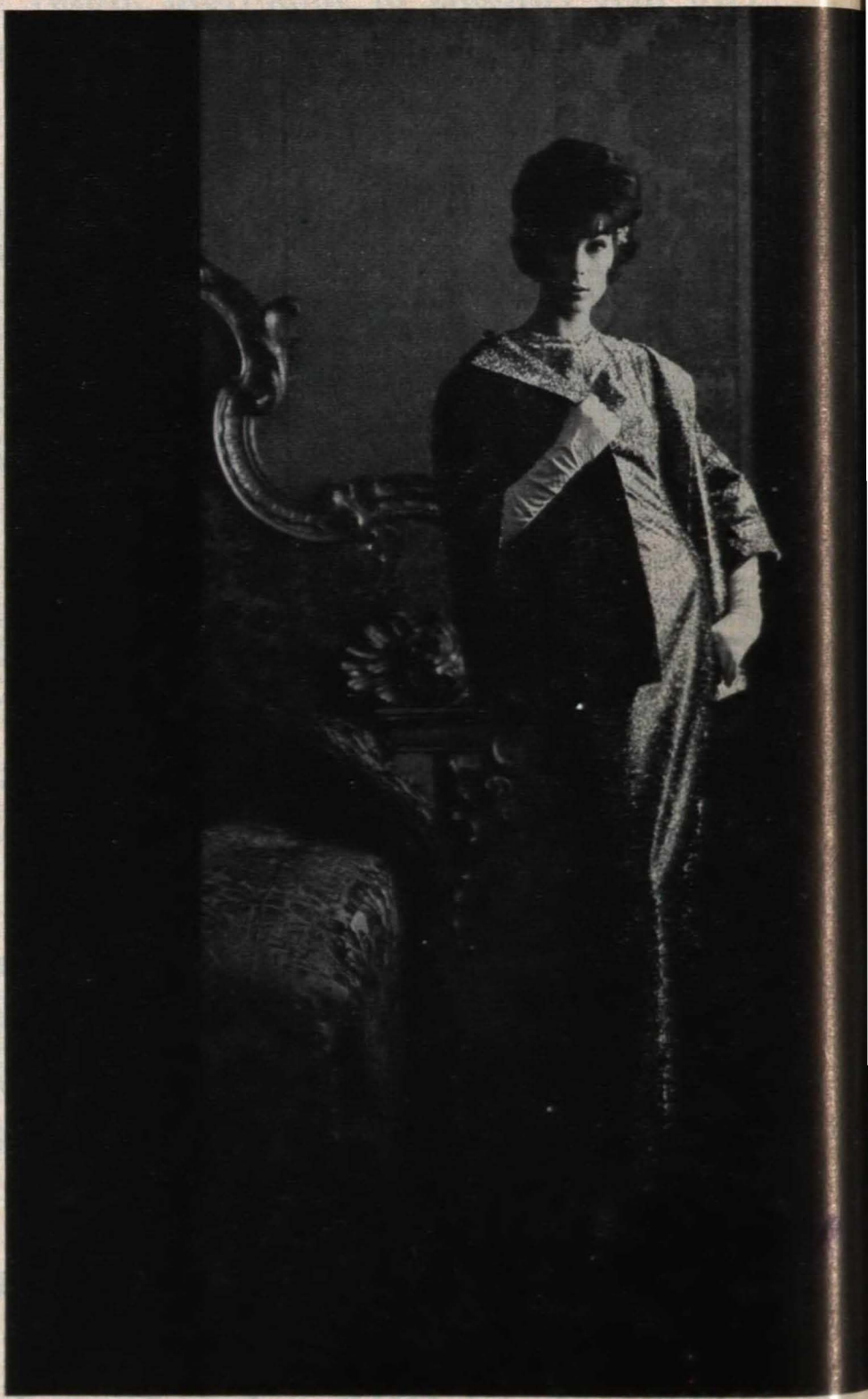

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In every one of 26 patients in whom there was "flooding" (associated with menorrhagia for which no organic cause could be isolated), non-hormonal therapy with duo-C.V.P. achieved "excellent" results as assessed by easy control of bleeding, improved sense of well-being, and ability to maintain normal activities. "In no case has there been any instance of side effects."[1]

The clinician attributes the anti-hemorrhagic effects of duo-C.V.P. to its apparent ability to restore normal small vessel structural integrity and function.

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CITRUS BIOFLAVONOID COMPOUND	200 mg.
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Bottles of 50, 100 and 500 capsules.

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references: 1. Prueter, G. W.: Applied Therapeutics 3:351, 1961. 2. Taylor, F. A.: West J. Surg., Obstet. & Gynec. 64:280, 1956. 3. Ainslie, W. H.: Obstet. & Gynec. 13:185, 1959. 4. Pearse, H. A., and Trisler, J. D.: Clin. Med. 4:1081, 1957.

*menorrhagia

Samples and literature from **arlington-funk laboratories,** division
u. s. vitamin corporation of canada, ltd.
P.O. Box 779, Montreal 3, Canada

MESSAGE FROM THE ICN PRESIDENT

This message appeared in the ICN News Letter, January, 1962.

Where are you today? In hospital, at the bedside of a patient; in a home, where you have been called to nurse a very sick person; in a health centre, proceeding with vaccinations; in an industry, working with the doctor who is examining newly-recruited personnel; on the road, at the wheel of your car, to visit a mother and her child in an isolated village? Are you in a snow-covered country, in the wind and the rain, or under a tropical sun?

Wherever you may be, may this message reach you, for you belong to the great family of nurses, whose *raison d'être* is the human being. For him you learn, you think, you act, you even suffer sometimes. To preserve his health, to prevent illness or accidents, to nurse him and to help him to recover, to help him to die, also, your will is to be always ready.

For all, the ICN wishes to be a living reality. Through your national associations, ICN wishes to sustain your efforts to improve always your education and your professional education, to help you to become always more efficient in your action, to realize your vocation more fully, and to find in this vocation the expansion of your personality.

Because you are nurses, you have a responsibility and a mission; a responsibility to be a highly qualified professional worker, exercising your art for the good of the patient; a mission, which is a mission of love in our disturbed world, which is so much in need of love.

May you exercise your profession with competence, with love, and in happiness. This is the wish I make for you, nurses of the world, on the threshold of this year 1962.

ALICE CLAMAGERAN, President

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AIR CANADA

the 'teens—a time of transition

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Why not suggest "Tampax" to the 'teenage patient? Its matter-of-fact simplicity, safety and security are sure to be welcome now and in the years ahead. Canadian Tampax Corporation Limited, Barrie, Ontario.

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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 58 NUMBER 3

MONTREAL, MARCH 1962

CHANGES AHEAD

CANADA HAS CHANGED dramatically during the past decade. With this change have come many demands on the nursing profession. Several factors are responsible, such as: advances in medical science, increased growth in population, and modifications in community structure. All of these indicate that new methods and new means must be devised to meet new needs. The role of the school of nursing in relation to these needs must be determined.

The Canadian Nurses' Association School Improvement Program has been developed to implement the second recommendation of the Report on the Pilot Project. Its main purpose is to assist schools of nursing to evaluate their own educational programs and to evolve means of improving them, using broad educational principles and criteria.

The schools of nursing requesting participation in this voluntary program, which commenced in March 1961, include 93 per cent of our hospital schools of nursing and 17 per cent of our university schools with 100 per cent participation in seven provinces. Eighteen regional conferences have been held, with at least one in each province. The purpose has been to interpret the program to key people in the health and educational fields as well as to assist the faculty of the schools in the use of the Self-Evalu-

(Paul Horsdal Ltd. Ottawa)

GLENNA ROWSELL

ation Guide and to develop a plan for self-improvement. Apparent at all the conferences was the trend toward transition and change which exists in our schools of nursing today. It was also evident that there was a need for clarification of the role of the school and the direction in which nursing education should be moving in relation to present-day needs for nursing care.

Many who attended the conferences realized that evaluation was much broader in concept than just testing and measuring. They became aware that it embodied the philosophy and adjectives, but of having those who lum content should be designed in the light of these philosophies and objectives.

Another problem facing the staff members of the schools of nursing was the need for clarification, for themselves and others, of what is meant by nursing. It was not so much a question of finding an appropriate combination of words, with the right adjectives, but of having those who practise nursing know, without a shadow of doubt, that what they are doing really *is* nursing. Perhaps we have assumed too much about nursing, and have not made our own role clear in the vast complex of health care.

It was observed by many that the motivations and attitudes of student nurses undergo changes during the course of their education. These changes are not always those which the school expected the student to acquire from the program.

The curriculum patterns, that have grown out of this search by the schools for a better way of educating nurses, have been varied in length and content. These are significant symptoms of the changing concepts of nursing responsibility and the development of curricula to provide the academic preparation and experience needed by professional nurses.

The logical expectation regarding a program such as this is that the schools will wish to make the areas, which they have identified as areas requiring improvement, the basis for their program for self-evaluation and self-improvement. The obligation to raise standards makes life very difficult at times, and adds a burden to the already busy program in the school.

GLENNA ROWSELL

The *Journal* salutes the nursing profession of the United States, at a time when it is being honored by the issuing of a **Commemorative Nursing Stamp.** One of the effects of this stamp, as expressed by Ivan Nestingen, the Under Secretary of Health, Education and Welfare, is that "people everywhere on the North American continent will have cause to pause and reflect on what nurses have meant to them directly and indirectly." Dr. Luther L. Terry, Surgeon General, Public Health Service, in his opening remarks at the first day ceremonies said, "With this stamp, we give well-deserved honors to all nurses who have earned our respect and our gratitude for their unstinting service. We who work in health and medical care see daily and firsthand the often-dramatic results which nursing care can accomplish — not for just a few patients but for hundreds and thousands of people."

LUCILE PETRY LEONE

The nurse in the photograph, Lucile Petry Leone, is well known to many Canadian nurses. Her contribution to nursing, through her position as Assistant Surgeon General and Chief Nurse Officer, Public Health Service and through nursing literature, has been extensive.

BRITISH COLUMBIA

WILLARD E. IRELAND, PH.D.

All too frequently we think of Canada's western province as new, yet our roots run deeply into the soil of this Pacific coast.

WELCOME TO BRITISH COLUMBIA in 1962! Do come and join us in our centenary celebration of Billy Barker's strike on Williams Creek. The discovery of gold changed the character of this western country, for no longer was it a fur preserve. The "bars" of the lower Fraser River first attracted miners who worked their way upstream until the great strikes were made in the interior and Cariboo. Its gold became a by-word all across the country and lured people from eastern Canada, and indeed, the world at large. In 1862 the hardy Overlanders made their epic trek across the country, and a new day began to dawn.

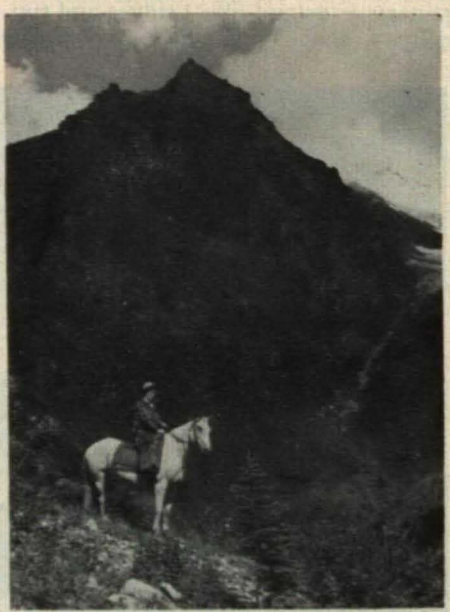
Canada had only been a British possession some nineteen years and the American Declaration of Independence was only two years old when Captain James Cook, R.N., in the spring of 1778, became the first British subject to land on Vancouver Island. He was the precursor of a great number of navigators and traders to visit these shores. In the spring of 1792, when engaged in surveying and mapping the coast of the Pacific Northwest for Great Britain, Captain George Vancouver, R.N., wrote:

> To describe the beauties of this region will, on some future occasion, be a very grateful task to the pen of a skilful panegyrist. The serenity of the climate, the innumerable pleasing landscapes, and the abundant fertility that unassisted nature puts forth, require only to be enriched by the industry of man with villages, mansions, cottages, and other buildings, to render it the most lovely country that can be imagined; whilst the labor of the inhabitants would be amply rewarded in the bounties which nature seems ready to bestow on cultivation.

These prophetic words, in so far as they may be applied to British Columbia, have long since become a reality.

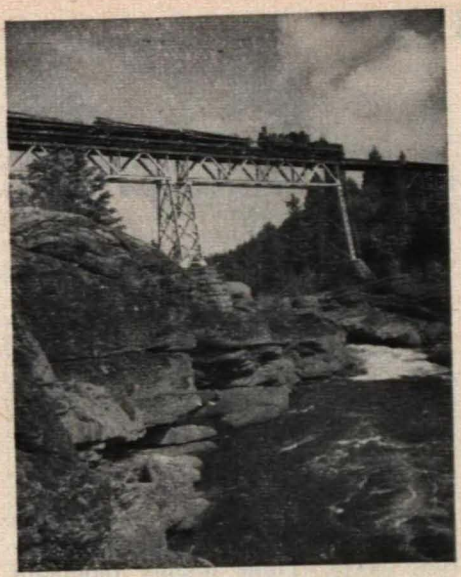
Scenic Grandeur

The natural beauties of Canada's Pacific province have made it a tourist's mecca. Three mighty mountain chains — the Rocky, Selkirk and Coast ranges — traverse its length, providing scenic attractions beyond description and opportunities for mountain climbing and skiing, unexcelled elsewhere on the continent. To be sure, in earlier times these mountains served as barriers to settlement but persistent and hardy pioneers pushed their way through. In their wake came the Canadian Pacific Railway which was completed to tidewater in 1886. This was the pioneer venture in transcontinen-



The Rocky barrier

Appreciation is expressed for their courtesy in supplying illustrations, to: Photographic Branch, Department of Recreation and Conservation for the many "British Columbia Government Photographs;" the Canadian Pacific Railway page 211; the Canadian Government Travel Bureau, page 216.



Railroading through the mountains

tal railroad construction in Canada. The building of the mountain division is an epic story of man's ingenuity pitted against nature's impassive obstinacy. Cuts and fills, bridges and tunnels — the Connaught tunnel under the Selkirks is five miles long — gave the victory to man. Today, four main lines of railroad penetrate the rocky barrier.

Once, when the construction of the C.P.R. was under discussion, a great Canadian statesman made deprecatory reference to British Columbia as a "sea of mountains." This, it was then felt, was the major handicap to the future progress of the region. In reality, therein lay the secret of its ultimate importance to Canada. Buried within these mountains were huge mineral deposits, the variety and value of which is only beginning to be realized. Moreover, mountains also mean valleys and in these valleys agriculture has flourished.

British Columbia has become an important producing province, being surpassed only by Ontario in per capita production values. In addition to its generous natural endowments British Columbia is also possessed of variations in climate which have contributed greatly to the variety of its economic life.

Paralleling and intersecting the mountain ranges are myriads of lakes

Lake Okanagan

and mighty rivers, adding variety to the scenic beauty and allurements to the inveterate angler. These were the original transportation routes. The Peace, Columbia, Fraser, Skeena, and Stikine rivers, some of them turbulent and dangerous, provided the natural lines of communication used by the explorers, the fur traders, and the pioneer settlers. The Pacific seaboard is dotted with innumerable islands of all sizes and hundreds of fiord-like inlets create a coastline estimated at over 8,000 miles. Towering cliffs rise five to eight thousand feet from the water's edge, hundreds of cataracts and waterfalls feathering their rocky slopes. Further to the north, impressive glaciers debouch into the sea itself. All this is set against a background of mighty evergreen forests and combines to provide pleasures without end for the itinerant visitor.

To illustrate the importance of these river valleys perhaps it would suffice to describe two typical regions, both of which have played an important part in the historical development of the province and which today contribute so greatly to its importance.

Okanagan Valley

Of the many valleys perhaps this is the most widely known. It lies in the southern interior of the province, close to the border of the United States. Mountain ranges flank either side of a crystal clear lake that extends some 80 miles from north to south. The lake is drained by the Okanagan River which empties, in turn, into the mighty Columbia River in American territory. In the early days, before there was permanent settlement along the coast, this valley had become an important commercial highway. The fur trade was the magnet that drew white men over the Rockies. At first their interest was farther to the north in the area opened up by the Peace River and its tributaries and farther to the south in the basin of the Columbia River. Trading posts were established in both areas. Eventually, the Okanagan Valley became the important link between the two regions. For years, vast quantities of supplies and furs passed over the "old brigade" trail.

Douglas Lake cattle country

As settlers began to push into the country from the more thickly populated east the fur trade dwindled and disappeared. The Okanagan Valley became a cattle country since the rainfall was so slight that ordinary agriculture was impossible. But, on the mountain slopes grass grew in abundance and for a time the cowboy reigned supreme. To refer to mountain "slopes" hardly gives the correct impression, for actually along both sides of the lake and at different levels of elevation are stretches of flat land known as "benches." The scene is completely changed today. Far back in the mountains dams have been built. From these, the water is carried to the "benches" in immense flumes from which it is distributed to the individual orchards by means of a series of ditches.

Spring in the valley is a glorious sight. Thousands of fruit trees in full blossom are banked on either side of the lake for miles and miles. In the late summer and early autumn the scene is equally fascinating for the air will be heavy with the perfume of

Miles of apple blossoms

ripened fruit. Thousands of boxes of apples, most famous of which is the MacIntosh Red, are sent to the markets of the world. Cherries, apricots, pears and peaches, cantaloupes and tomatoes are grown in abundance.

Fraser Valley

The Fraser River, nearly 750 miles in length, is the largest of the many rivers of the province and derives its name from that intrepid explorer, Simon Fraser, who descended the river to its mouth in 1808. Rising high in the Rocky Mountains, at first it flows in a northerly direction then makes a sharp bend near the city of Prince George to begin its headlong rush southward to the sea. In the interior it passes through and drains a large plateau area part of which, particularly the Chilcotin country to the west, is important for cattle. At Lytton, the muddy Fraser joins with the Thompson from the east then plunges into a narrow gorge to break through the Coast Range which bars it from the sea. Cataracts, whirlpools, and rapids, with the sheer perpendicular walls of the canyon rising in many places several thousand feet, combine to make an awe-inspiring sight to which any traveller can bear witness, for both transcontinental railways use this route to the coast.

Automobile traffic through the canyon was made possible with the construction of the scenic Cariboo Highway. A trip over this road cannot fail to thrill the visitor, the more so when it is recalled that much of the route follows the original Cariboo Road. The necessity of providing means of access to the rich gold fields of the Cariboo district, centring about Barkerville, impelled the construction of the original highway in the early 1860's in the face of almost overwhelming difficulties. Today, the sound of the motor horn has replaced the crack of the bull-whip. While we no longer see the creaking old stage-coach, wearily climbing the long grades and warily edging its way along what was little more than a ledge carved out of the precipitous canyon wall, nevertheless one cannot but feel humble at the memory of this monument to the pioneering spirit.

Freed of its narrow rocky confines as it rushes through Hell's Gate, the Fraser River begins a more leisurely course through a gradually widening valley. For thousands of years this madly rushing river has been carrying down the fine silt washed from its banks in the upper country. In consequence, in its slower reaches near its mouth there has been built up a large, typically fan-shaped delta some 30 miles wide at its seafront. Point Roberts forms the seaward extremity of the southern boundary of this delta while to the north is the city of Vancouver, which lies between the north bank of the Fraser River and Burrard Inlet. The river still continues annually to deposit large quantities of sediment, thus necessitating the constant dredging of the ship channel which leads up-river to New Westminster, British Columbia's thriving fresh-water port. It is one of the curiosities of history that although Captain Vancouver, after whom Canada's leading Pacific port is named, noticed the discoloration of the Gulf of Georgia caused by the muddy water from the Fraser River, he failed to discover its existence although he passed within a few miles of its mouth.

Small fruit farming

Agriculture

The rich soil of the Fraser River delta is now under intensive cultivation. Both here and in the immediately adjacent valleys immense crops of hay and grain are raised. An extensive dairy industry has grown up which finds a ready market in the metropolitan area of Vancouver. In addition, hundreds of small "truck-farms," producing vegetables for the urban area, are scattered over the

A gladioli farm

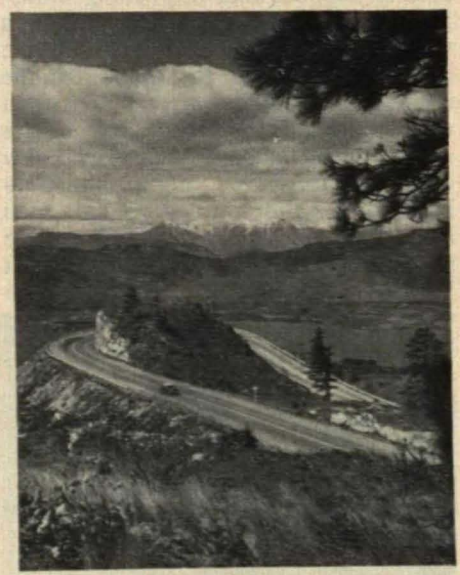
delta, many of them operated by the industrious Chinese. Farther up the valley small fruits of every kind — strawberries, raspberries, loganberries — are grown in large quantities.

Agriculture, which is British Columbia's third ranking industry, is not confined only to these two river valleys. It flourishes in all sections of the province. Parts of Vancouver Island are admirably suited to small fruit farming, for good soil is here combined with an excellent climate. Thanks to the tempering effect of the Japanese current the whole of the coastal area enjoys a salubrious climate which, with the assurance of ample rainfall, makes for successful farming. Much farther to the north the grain growing potentialities of the Peace River Block and of the Bulkley Valley are well known. The total value of the agricultural products of the province amounts to nearly $130,000,000 of which dairy products, fruits, fodders, poultry products, and livestock contribute over 60 per cent.

Mining

Had British Columbia been solely dependent upon agriculture her progress would, in all probability, have been very slow. The first forward step in her path of progress came as a result of the gold discovered on the Fraser River, the resulting gold rush in 1858, and the successful development of the Cariboo gold-fields in the 1860's. Since that time, mining in general and gold mining in particular has been one of the leading industries of the province. It is a far cry from the pan and wooden cradle and "long Tom" methods of the argonauts of the mid-eighteenth century to the huge hydraulic operations of today. In addition, placer mining has to a large extent been superseded by quartz or lode mining. The various centres of gold mining operations produce about one-twelfth of the total Canadian gold output.

The untiring efforts and unconquerable optimism of the prospector soon unearthed the vast mineral wealth locked in the mountains of British Columbia. In extent and variety the mineral resources defy summary description. The turning point came in the late 1890's with the great boom in base metals. The centre of provincial activity was the Boundary country in the southern interior, with Greenwood, Phœnix, and Rossland as



In the Boundary country

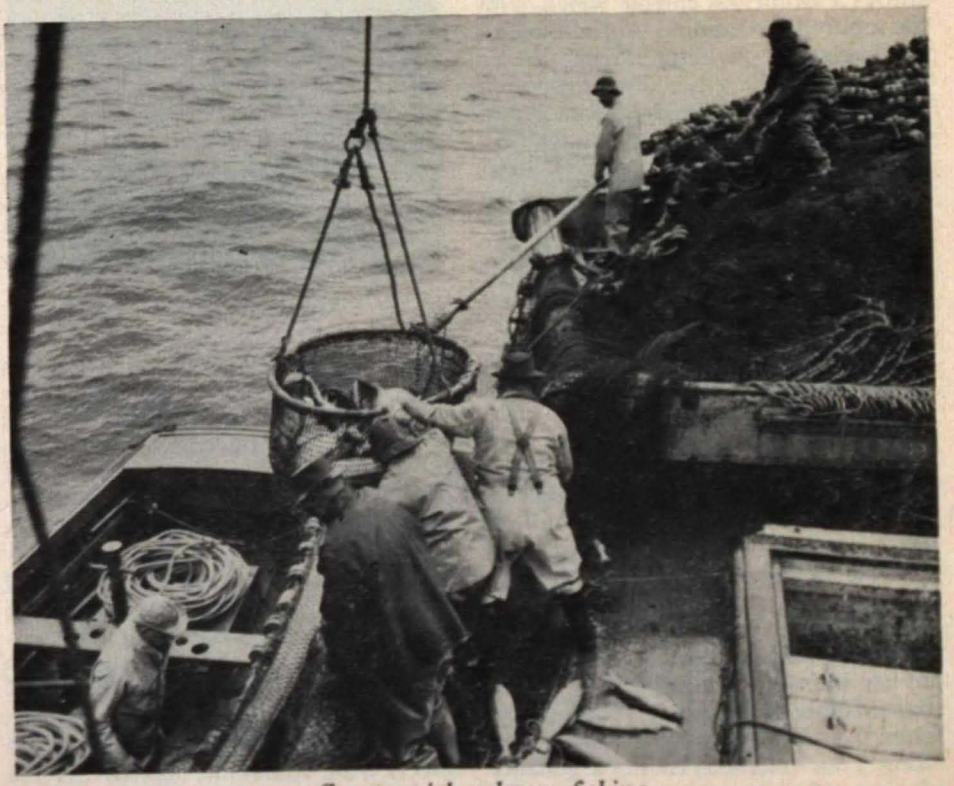
typical boom towns. Vast quantities of lead, zinc, and especially copper were mined. Though in due course the boom collapsed, nevertheless the basis for a mining industry had been well laid. The discovery of a method whereby the complex ores from the Sullivan mine at Kimberley — one of the largest hard-rock mines in the world could be treated led to the development of the enormous property of the Consolidated Mining and Smelting Company at Trail. Today, British Columbia ranks first among the other Canadian provinces in the production of silver, lead, and zinc, as well as the rarer metals of the cadmium group.

Large copper properties are in operation, notably the Britannia Company on Howe Sound, near Vancouver. Coal is also mined in such widely separated districts as Nanaimo on Vancouver Island and Fernie in the heart of the Kootenay country in the Rocky Mountains. In recent years, there has been considerable activity in petroleum and natural gas production which contribute more than 5% of the total annual mineral production, now in excess of $175,000,000.

A marvellous day's catch

Fisheries

To many people the name "British Columbia" is immediately associated with salmon. With such an immense length of coastline it was only reasonable to suppose that the fishing industry would be highly developed. In a sense this is the pioneer industry for, in the years before the coming of the white man, salmon was a staple food of the Indians and they were fully aware of the phenomenon now know as the "run." The young salmon is hatched in interior waters but soon finds its way to the sea where for three years it disappears. Then, suddenly, it re-appears on the coast seeking to return to the very spot where it had hatched. Unlike the Atlantic species, the Pacific salmon never returns to the sea, as it dies either on its way to the spawning grounds or shortly after it has reached them. This instinctive urge, which forces the salmon to battle its way against the current of the swift-flowing British Columbia rivers, produces the "salmon run." During this season, fishermen are busy at the entrance of all the rivers leading to the interior and canneries have been built in close proximity. The Fraser, Skeena, and



Commercial salmon fishing

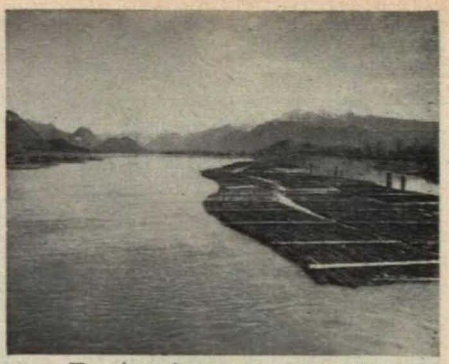
Nass rivers are particularly important centres. Unfortunately, a few years ago, there was a marked decline in the "run," in all probability due to the policy of unrestricted fishing. In an effort to conserve the supply, the government established hatcheries and built fish-ladders to assist the salmon over the obstacles in the rivers which retard its return to the spawning grounds.

The salmon alone accounts for about two-thirds of the total value of the provincial fisheries. Gradually, the halibut fishery is coming to be of greater importance. This industry is centred about Prince Rupert and involves an entirely different technique from that used in the salmon industry for the halibut is found miles off-shore on the "banks." This industry has also increased the herring fishery, as herring are the bait used in catching halibut. Salt herring normally finds a market in the Orient.

In bygone days the departure and return of the sealing fleet were great events but this industry has almost entirely disappeared. On a very limited scale, however, the equally intriguing whale fishery is still carried on from bases on the Queen Charlotte Islands.

Lumbering

One of the crowning beauties of British Columbia is its evergreen forests. Towering Douglas firs, cedars, and spruce cloak the hills and mountains of the coastal area from sea-level to snow-line. Of them all the Douglas fir is the most majestic, for it often reaches a height of 150 feet with a girth exceeding 30 feet. Economically, the forests are our greatest asset for annually they produce values well in excess of $675,000,000. From both the esthetic and economic points of view it is unfortunate that improvident logging methods and ravaging forest fires annually destroy thousands of acres of timber, but it is to be hoped that in the future greater efforts will be made to assure the continued existence of this double asset. The close proximity of the better stands of timber to water has made the problem of transportation of the logs to the saw-mills an easy one for solution in British Columbia. While in some localities log-trains are used, the more common sight, even in the interior, is the huge boom of logs being towed by a tug to the saw-mill. Vancouver, New Westminster, and Port Alberni are the centres of this industry and from these ports sawn lumber and shingles move quietly over the oceans to the four corners of the earth.



Towing logs to the mills

A fallen giant

Move quietly over the ocean

A lumber mill in New Westminster

Paper Making

Of increasing value in recent years is the allied pulp and paper industry. In this respect British Columbia is most fortunately situated. An abundant rainfall in the coastal area makes it possible for its many rivers to afford excellent all-year-round sites for hydroelectric developments in close proximity to the forests. Cheap power, a prime requisite for the successful conduct of this industry, is consequently readily available. Large and valuable pulp and paper mills are to be found at Ocean Falls, Powell River, and Port Alberni.

Boundaries Problems

From the foregoing account it would seem only just that British Columbia, without undue presumption, might claim for itself a rather meteoric rise to prominence. Admittedly its tremendous extent — 366,255 square miles — and abundant natural resources contributed in no small degree to its progress. But the province has never had a large population; even today, it only numbers slightly over a million and a half, less than the population of greater Montreal or Toronto. Consequently, its accomplishment has been the result of the diligent labor of an enthusiastic people who are as resolutely confident of the future of their province as they are proud of its past history. Yet it must never be forgotten that British Columbia is a *young* country, for it is just over one hundred years since the first serious attempt was made to settle the region now comprised within its boundaries.

Attention first came to be centred on this part of the Northwest Pacific because of a small marine mammal, the sea otter, whose pelt found ready sale in China. A Russian explorer, Vitus Behring, made the initial discovery but it did not become general knowledge until after the visit of Captain Cook in 1778. The Spaniards had been gradually pushing their explorations northward from Mexico and four years prior to Captain Cook's arrival had actually sailed in the waters off this coast. But to the British navigator goes the honor of having made the first landing on these shores and also the credit for having made the first chart of the coastline. The possibility of

enormous profit from the sale of the sea otter pelts drew traders of all nationalities to the Pacific Northwest. The first, Captain James Hanna, an Englishman, after a sojourn of but a few weeks on the coast, sold his cargo in Canton for $20,000. Soon, Spanish, Russian, and American traders were actively engaged in the trade. Inevitably, commercial rivalry gave place to international animosity. The most serious rivalry developed between Great Britain and Spain and almost precipitated a war. Ultimately, the Nootka Sound Convention was drawn up which, to all intents and purposes, left the whole region open to traders of any country. Captain Vancouver was sent out to carry through the provisions of this agreement and, in addition, to explore and chart the coast, for at that time the fabulous Northwest Passage between the Atlantic and Pacific oceans was still being sought. Captain Vancouver spent three years at work on this coast, producing maps and charts that are considered amazingly accurate even today.

All the activity in the maritime fur trade centred around Nootka Sound, an inlet on the west coast of Vancouver Island. With the sudden collapse of the Chinese market the whole trade disappeared. Nootka sank into insignificance; in fact, nothing permanent remains as a relic of an important and romantic period in the history of the province.

Just at this stage, the possibility of an overland fur trade was investigated. The North West Company, a Canadian fur trade concern, was seeking to penetrate into the country west of the Rocky Mountains and gave every encouragement to exploration of the unknown region. In 1793, one of their employees, Alexander Mackenzie, became the first white man to come overland from eastern Canada to the North Pacific. His was an epic voyage. Accompanied by a small party of voyageurs he followed the Peace River pass through the Rocky Mountains and eventually reached the upper stretches of the Fraser River. As this stream led southward and as his objective lay westward, Mackenzie branched off. After following an old Indian trail and enduring untold hardships he reached tide-water at the mouth of the Bella Coola River which empties into Bentinck Arm. Simon Fraser's equally hazardous journey was also sponsored by the North West Company in their quest for knowledge of the country.

Soon trading posts were established — at first in the area adjacent to the Peace River pass, but soon further afield, even as far as south as the Columbia River. In 1821, the North West united with the Hudson's Bay Company and thereafter British interests in the territory west of the mountains were left almost wholly in their hands. They made every effort to maintain control of the region and were at first completely successful. Naturally, their prime interest was the conduct of the fur trade and, in consequence, colonization of the country was ignored. At this time neither the United States nor Great Britain possessed the title to the country west of the Rocky Mountains for, by agreement, it had been left open to the citizens of both countries.

In the 1840's a steady stream of American settlers began to pour over the mountains into the Columbia Valley. The settlement of the boundary question thus became a necessity but it was difficult to reach a satisfactory solution. The British laid claim to all the territory as far south as the Columbia River while the United States laid a counter-claim as far north as 54° 40'. Public opinion in both countries became aroused. In the United States, the cry "Fifty-four forty or fight" became part of an election campaign in 1844. Once again the possibility of war was imminent but good sense prevailed. The Oregon Treaty of 1846 adopted a compromise boundary along the 49th parallel, thus setting the southern limit of British Columbia.

Establishing Government

This advance of the American frontier aroused the British government to action. In order to forestall any further intrusion it was decided to establish a British colony on Vancouver Island. In 1849, this plan became a reality under the auspices of the Hudson's Bay Company as sole proprietor of the colony. Provision was made for a royal governor. The first appointee, Richard Blanshard, arrived at Fort Victoria on March 11, 1850.

The Marina in Vancouver Harbor

He did not remain in the colony long for the real power was in the Chief Factor of the fur company — James Douglas. In 1852, Douglas became governor and by his years of service earned for himself the title "Father of British Columbia." That same year, because of gold discoveries on the Queen Charlotte Islands, that archipelago was added to the original limits of the colony. Unfortunately, the colony of Vancouver Island did not prosper. For one thing, the gold fields of California were much more attractive to the would-be colonist and, in addition, the Hudson's Bay Company was not an ideal colonizing agency. By 1855 scarcely 750 whites resided on the island, yet despite its small population it possessed the full government of a typical crown colony. In fact, the first legislative assembly to be convened west of Toronto in British territory met in Victoria in 1856 and was composed of seven members.

During all this time, the mainland still remained a fur preserve of the Hudson's Bay Company. Soon, gold discoveries became the *open sesame.* In 1858, when news of the rich finds reached California, a regular stampede to the Fraser River ensued. Thousands of expectant miners poured into the country within a few months. In response to this totally unexpected situation the separate mainland colony of British Columbia was established with James Douglas as governor. As the miners pushed further inland from the bars of the lower Fraser, other valuable mining fields were opened up. Barkerville came, temporarily, to be one of the largest towns on the continent west of Chicago. Each advance of the miner increased the problems and the expense of government in this huge area. Roads had to be built and the terrain was particularly difficult. Mention has already been made of the construction of the famous Cariboo Road under the supervision of the Royal Engineers sent from England. In 1862, gold was discovered still further north on the Stikine River. Once again a separate colonial administration was established with the creation of Stikine Territory, with Douglas as administrator.

Like most gold rushes the boom days soon passed away and a period

of depression set in. Population dwindled, business was stagnant, taxation was unduly heavy, and discontent began to grow. Even Victoria, which had become a thriving commercial centre as a consequence of the gold rush, shared in the decline along with the mainland colony. In an effort to economize, in 1866 the various colonial administrations were united under the name of British Columbia. For a time the capital of the united colony was New Westminster but it was soon changed to Victoria where it has remained ever since.

This union, however, did not bring the anticipated relief. Once again British Columbia sought a remedy. In 1867, two events occurred that suggested possible ways out of the difficulty. That year the United States purchased Alaska from the Russian government. With British territory thus sandwiched between American possessions, some came to look upon annexation to the United States as the solution of British Columbia's problems. That same year, Canadian confederation had been launched and many British Columbians eagerly anticipated the inclusion of their colony in the new Dominion. Annexation to the United States was from the beginning a lost cause. The colony of British Columbia became a province of Canada on July 20, 1871.

One of the terms of union called for the construction of a transcontinental railroad, for without such a link the union was doomed to be more apparent than real. After long delay, in 1886 the Canadian Pacific Railway was completed to tide-water on Burrard Inlet and British Columbia became in fact a part of Canada. Since then, her progress has been rapid and extensive. No better evidence of this fact is to be found than in the history of the city of Vancouver. In 1886 there were only a few struggling settlers. Today, it is a great Pacific port, gateway to the trade routes of the world.

IN THE GOOD OLD DAYS

(*The Canadian Nurse* — MARCH 1922)

It is within the experience of most people who visit in hospitals that they are greeted with curt questions or are ignored altogether. Should they by mistake call to see a patient when it does not happen to be a "visiting day" they may find themselves looked upon as social outcasts and treated as such. Even in reply to a question as to the bed where a patient may be found has been known to be given with a vexed inflection of voice or an air of infinite boredom by the nurse on duty.

Everywhere hospitals are crying out for public support. The authorities would do well to be careful that none of their subordinates cultivate an attitude toward strangers that will alienate sympathy and dry up possible channels of help.

* * *

There are no reliable statistics regarding the incidence of venereal disease in any country. This is due to the fact that the stigma attached to these diseases by the public makes it difficult and impractical for public health authorities to require general notification of the diseases.

* * *

A survey by the National Public Health Section revealed that there were 997 nurses engaged in public health nursing in Canada, of whom 242 were with the Victorian Order of Nurses.

* * *

The Hospital Association of Philadelphia is experimenting with a new plan. Beginning in September 1922, the preliminary course in nursing education, now being taught in 50 separate training schools in that area, will be given at one time and in one place.

* * *

Six hundred and thirty four decorations or citations were conferred upon the members of the Canadian Army Nursing Services during the war of 1914-18. Of these, 82 received the Royal Red Cross, 251 the Associate Red Cross medals.

Status and Remuneration of Federally Employed Nurses*

EVELYN A. PEPPER, B.N. *and* ETHEL M. GORDON

A Submission to the Royal Commission on Government Organization by the Registered Nurses' Group of the Professional Institute of the Public Service of Canada.

THE FEDERAL GOVERNMENT is the largest single employer of nurses in Canada. Approximately 2400 professional nurses are required to staff federally operated hospitals and other governmental health services throughout the country. Only 5 per cent of these nurses are in senior administrative positions. The large remaining group are engaged in bedside nursing, public health or occupational health nursing and in head nurse activities.

For several years there has been an active Registered Nurses' Group within the Professional Institute of the Public Service of Canada. The primary purpose of this group, in keeping with the over-all objectives of the Institute, is to ensure satisfactory employment conditions for its members while maintaining a high quality of nursing services within government employment.

Since its inception, the leaders of this Group have been very much aware of the deterioration of patient care due to the high number of vacancies and excessive rate of turn-over of professional nurse staff in government hospitals. We believe that this situation can fairly be attributed to the depressed nature of nurses' salaries throughout Canada.

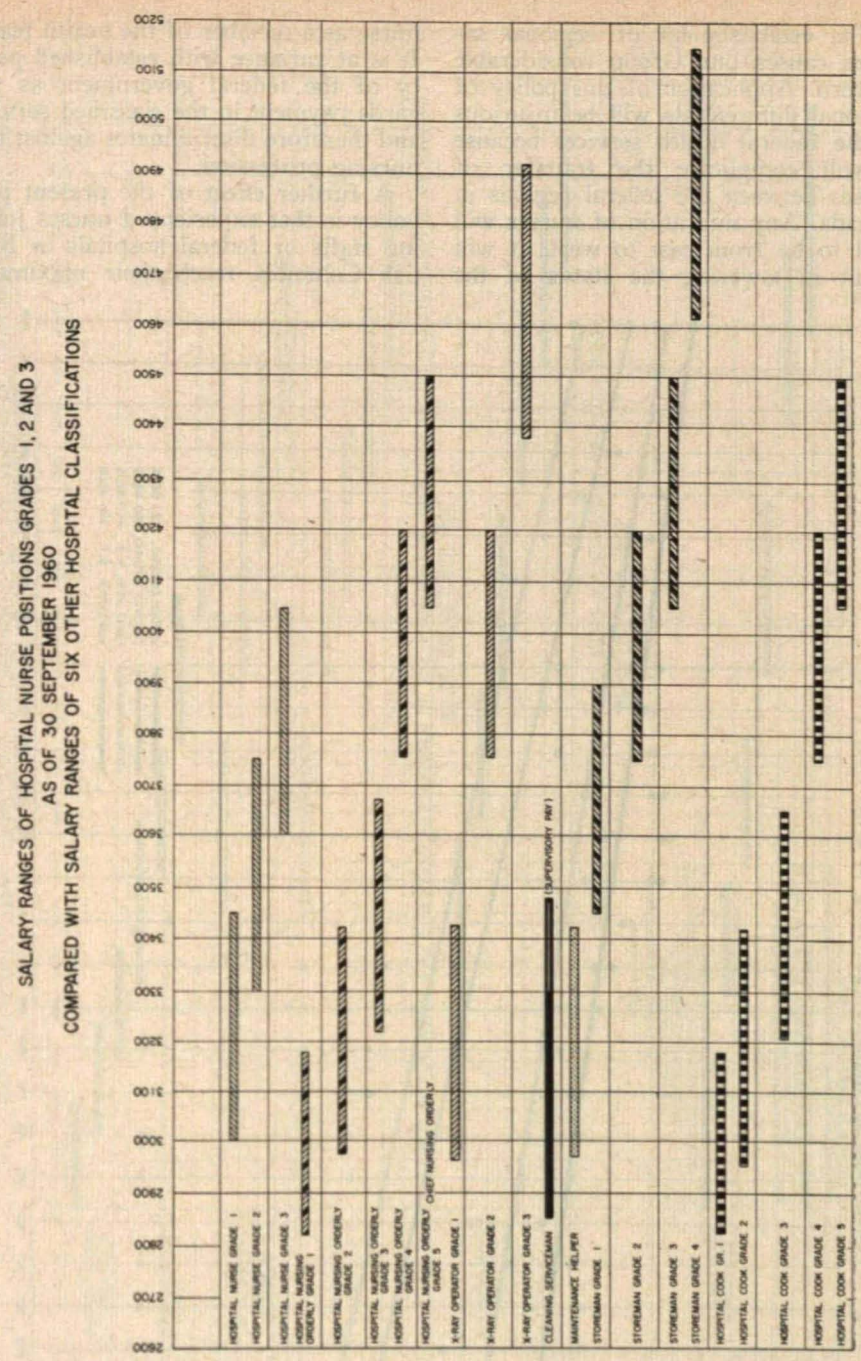
Because of the seriousness of this situation and at the request of the Registered Nurses' Group, a special Nurse Salary Committee was set up in 1960 within the Professional Institute. The findings of this committee are summarized in Charts 1 and 2 that follow.

In December, 1960, the committee presented its findings to the chairman of the Civil Service Commission and senior members of his staff. At that time, the committee representatives pointed out the fallacy of the federal government expecting to obtain the necessary quantity and quality of nursing care to meet long-range federal planning for hospitals and other health services if basic nursing were continually grossly underpaid.

A new nurse series, consisting of eight nurse classes, with detailed specifications for each class, was announced by the Civil Service Commission in May, 1961. Salary adjustments for the new nurse classes were announced at the same time. It was noted with satisfaction that considerable improvement has resulted in the senior supervisory and administrative classes now classified as Nurses 4 to 8. Also, the new regulations provided additional remuneration for specialty training to the Nurse 1 and 2 classes and a supervisory allowance to the Nurse 1 class. Although the amounts of pay increases were small, this action was recognized as a step in the right direction.

The chief objection of the Nurse Salary Committee to the over-all announcement of the new Nurse Series and related salaries, was the very meagre basic benefit derived by over 2200 professional nurses employed in the Nurse 1, 2 and 3 classes. The committee believes that their recommended salary ranges of $3600 - $4500 for Nurse 1; $4560 - $5160 for Nurse 2; and $5100 - $5820 for Nurse 3 were extremely conservative. In the opinion of the committee, as well as the Registered Nurses' Group, these were the lowest figures which would begin to bring the bedside nurse, the head nurse, the hospital matron (Matron 1 in the old series) and the public health nurse

*Reprinted, with permission, from the October, 1961 issue of *Professional Public Service*, the journal of the Professional Institute of the Public Service of Canada.

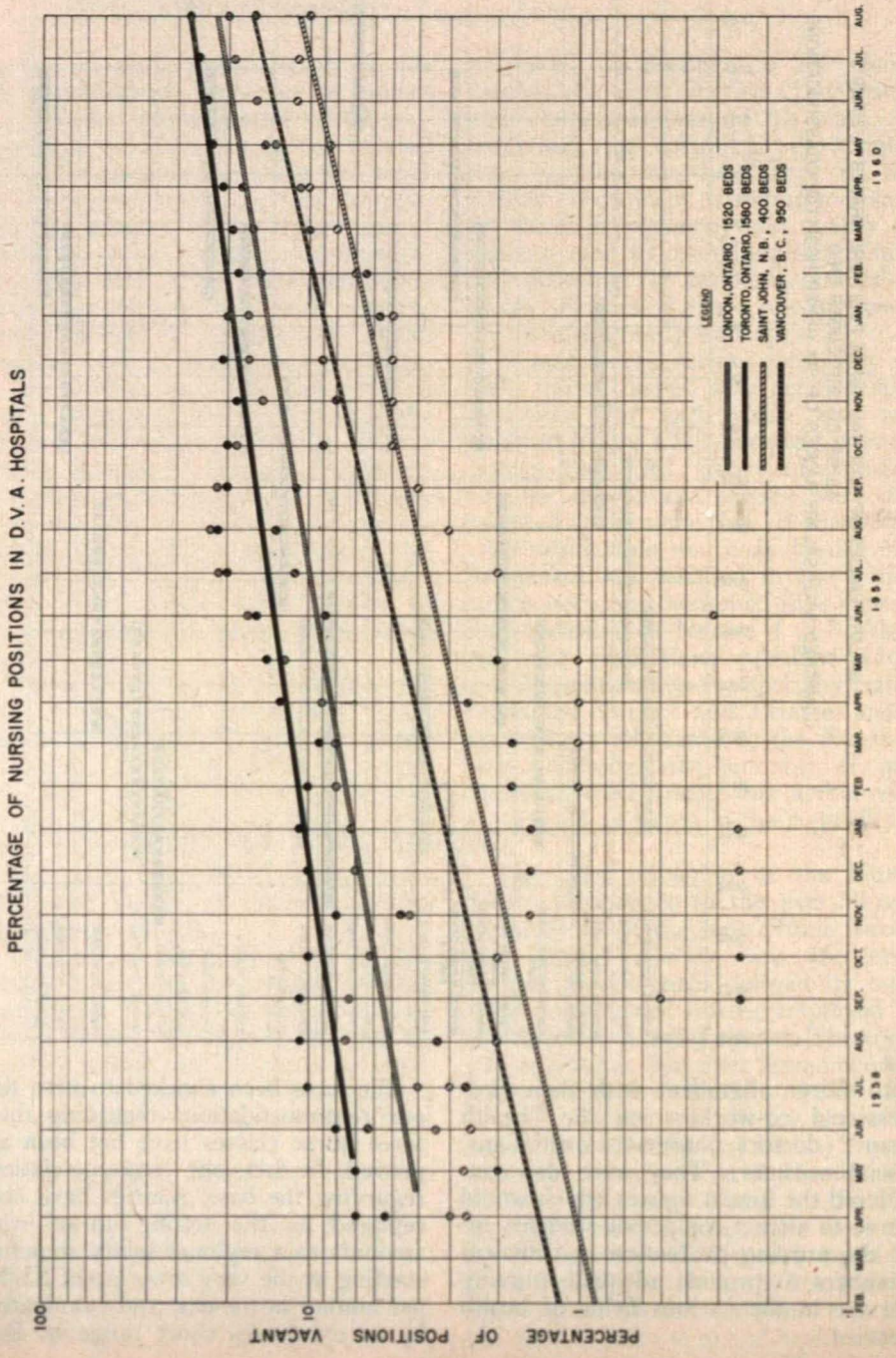


into fairer alignment with their professional co-workers on the "health team" (doctors, pharmacists, dietitians, social workers). They were also considered the lowest figures which would serve to attract competent students into the nursing profession in sufficient numbers to provide adequate nursing service in the various fields of health service.

We have been shocked to note that our recommendations regarding these three nurse classes have not been approved. In fact, our recommendations regarding the basic salaries have been replaced by the setting up of what amounts to a regional salary structure starting at the very low rate of $3,000 per annum in the east and culminating in an extremely short range in B.C.

The establishment of regional salaries causes our Group considerable concern. Application of this policy of regional differentials will be injurious to the federal health services because it will complicate the transfer of nurses between the several regions in Canada. Any migration of nurses will tend to be from east to west. It will result in lowering the status of the nurse as a member of the health team. It is at variance with established policy of the federal government as regards payment in the classified service and therefore discriminates against the nursing profession.

A further effect of the present pay policy is that experienced nurses joining staffs of federal hospitals in British Columbia reach their maximum



salary within one year of their employment. This will lead a large number to seek higher salaries in employment outside the public service. It can only lead to greater instability in nursing service and further difficulty in the provision of health services.

Despite the recent salary revisions, the problem in the classes Nurse 1, 2 and 3, remains essentially untouched. Vacancy rates are still high; competent loyal staff are continually being imposed on by staff turnover, staff shortages, part-time and short-term employment. Federal nurse employees in the Atlantic provinces are still being paid at about the same rates as hospital nursing orderlies. In addition to creating a highly unstable employment situation, these cumulative factors act as

deterrents to a career service for nurses within the government of Canada.

It is evident that the pay determination methods used by the federal government have failed to correct its nurse employment situation. The present method of comparing the salaries of federally employed groups with those of comparable outside groups is only sound and fair in classes that have kept pace with the rise in labor income, post-war inflation and high levels of consumer demand. This, the salaries of nurses have noticeably failed to do.

We believe that unless the government of Canada becomes interested in this matter from the national point of view, quite apart from its interest as an employer, the very existence of this key profession is threatened. With vast numbers of young women studying for more lucrative professions, the recruitment of professional nurses to hospital and other health services right across Canada becomes increasingly difficult. This is already reflected in the steadily increasing nurse vacancy rates in federal and general hospitals.

The situation is further aggravated by the large number of nurses emigrating from Canada to the United States. This number increased noticeably in the 1959-60 period. Despite concerted action to foster immigration from European countries we are experiencing a net loss of some 300 nurses per year. Also, as per capita income is presently increasing at a more rapid rate in Western Europe than in Canada, we have reason to believe that the supply of nurses from abroad will diminish.

Because of hospital insurance, hospital construction and shareable costs to provide for increased health services, there is a growing demand for professional nurses throughout the country. The supply of professionally trained nurses must increase to meet this need. It would seem wise that the government of Canada take leadership in establishing conditions of employment and an adequate pay formula which will encourage young students to seek a career in the nursing profession. Otherwise, we are convinced that there is little hope of maintaining efficient and stabilized nursing service within the federal government and all other health institution and services. We are also convinced that by assuming leadership the government would attract more young women into the profession and result in better health services for all Canadians.

A study of the stresses and satisfactions experienced by student nurses shows that the average student is happiest when working with patients. This compensates for the problems caused many students by lack of supervision, excessive responsibility, heavy work loads and poor orientation to the hospital.

The inquiry has implications for schools of nursing, for school-affiliated hospitals where students receive clinical experience, and for other hospitals and agencies which provide specialized field experience for students.

Research was conducted in 29 fully accredited schools of nursing randomly selected within 1,000 miles of New York City. Six of the schools provide four- or five-year college degree programs; the remainder offer three-year hospital diploma programs. Comparative data were collected from 1500 women enrolled in programs other than nursing in a random sample of 15 undergraduate colleges for women.

The study, conducted at the Institute of Research and Service in Nursing Education at Teachers College, Columbia University, was carried out with a grant from the United States Public Health Service. A report, entitled, *Satisfying and Stressful Situations in Basic Programs in Nursing Education*, describes the findings of the five-year project.

* * *

Prompt diagnosis and treatment, in infants as young as three weeks of age, can prevent the severe mental retardation associated with phenylketonuria (PKU). A blue-eyed, fair-skinned, blond infant with vomiting of unknown etiology and signs of unusual nervous irritability should be carefully evaluated. If the child is between three and six weeks of age, a positive ferric chloride dip stick urinary test is indicative of PKU. Dietary therapy initiated by the age of two months and adequately continued, practically assures that normal mental development will not be retarded.

J. Amer. Osteopathic Ass., Nov. 1961.

In Memoriam

Audrey Esme (Doughty) Andrews, a graduate of Hammersmith Hospital, London, England in 1946, died December 1, 1961. She had been employed as an office nurse.

* * *

Ella M. Bastian who graduated from Wellesley Hospital, Toronto in 1920 died late in 1961.

* * *

Ruth Gertrude Bryan, a graduate of the Jewish Hospital, Cincinnati, Ohio, died in Whitby, Ont. on October 29, 1961. She was in her 90th year.

* * *

Clara G. (Tremeer) Cann, a 1918 graduate of Toronto Western Hospital, died November 27, 1961. She was the assistant registrar at the Central Registry, Toronto.

* * *

Mary (Kendall) Chapiel who graduated from St. Paul's Hospital, Saskatoon in 1941, died in Winnipeg on December 7, 1961.

* * *

Anne (Valler) Cully who graduated from the Ontario Hospital, Mimico, Ont. in 1935, died in Toronto on November 29, 1961.

* * *

Bessie (Speers) Currey, a 1918 graduate of Dauphin General Hospital, Man., died in Kamsack, Sask. on December 3, 1961. She was on the staff of the Kamsack Union Hospital at the time of her death.

* * *

Marion Dewar who graduated from Montreal General Hospital in 1909 died suddenly in Pembroke, Ont. on December 1, 1961. For many years she was in charge of the health service of the T. Eaton Company, Limited, Montreal.

* * *

Ivy (Cameron) Doty, a 1925 graduate from Brandon General Hospital, Man., died November 14, 1961.

* * *

Elsie Maude (Griffis) Edwards who graduated from Plummer Memorial Hospital, Sault Ste Marie, Ont. in 1924 died on October 10, 1961 in Newberry, Michigan, U.S.A.

* * *

Hattie S. Gordon, a 1914 graduate of New York City Hospital, Welfare Island, N.Y., died in Toronto late in 1961.

* * *

Hilda (MacDonald) Griffith who graduated from Brockville General Hospital, Ont. in 1923, died late in 1961. She had been employed as a physiotherapist.

* * *

Florence Hill who graduated from Toronto General Hospital in 1912 died on December 8, 1961. She served overseas during World War I and upon her return nursed in Christie Street Hospital, Toronto for several years. She was a former matron of Westminster Hospital, London, Ont.

* * *

Delight Jeannette Elspeth (Mutch) Jarvis, a graduate of the Ontario Hospital, Kingston in 1943, died on August 11, 1961.

* * *

Olga Marie (Friesen) McCutcheon, a 1956 graduate of Vancouver General Hospital, died on December 14, 1961.

* * *

Cecilia (O'Brien) McNally, a member of the first class to graduate from Providence Hospital, Moose Jaw in 1920, died in December, 1961. Her professional life was spent in private nursing.

* * *

Ino (Simpson) Macaulay who graduated from Victoria General Hospital, Halifax in 1925, died on December 20, 1961 after a long illness.

* * *

Agnes Frances MacLean, a 1931 graduate of Wellesley Hospital, Toronto, died in November, 1961.

* * *

Mary (White) Murdoch who graduated from the Winnipeg General Hospital in 1910, died on August 28, 1961 in Saskatoon following a brief illness.

* * *

Elva Isabell Paul, a 1922 graduate of Toronto General Hospital, died on October 27, 1961. She had worked as a serologist in recent times.

* * *

Mary A. Pogson who graduated from St. Joseph's Hospital, Toronto in 1934, died on November 20, 1961 in Victoria. She was in the service of the Royal Canadian Navy.

* * *

Donna Joy (Bradford) Raithby who graduated from St. Joseph's Hospital, London, Ont. in 1959, died during 1961. She had engaged in institutional nursing.

* * *

Isobell T. Reid, a 1932 graduate of St.

(*Continued on page* 231)

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three exciting new styles

brilliantly executed in the
very distinguished horrockses
"minimum-iron" cotton

Known the world over as a standard of excellence in cotton fabrics, Horrockses "minimum-iron" cotton has now been perfected to meet the rigid White Sister uniform fabric requirements! This very luxurious fabric offers elegance in looks, drape and feel. It is soft and plush, yet it remains work-day sturdy to provide long service. It is with great pride that White Sister adds this most distinctive cotton to our ever-increasing "Family of Fine Fabrics" and herewith presents three exciting selections executed in the very distinguished Horrockses "minimum-iron" cotton.

A **TUCKED FOR BEAUTY**—A rounded bib yoke is richly filled with diagonal multiple tucking and highlighted with tiny decorative buttons for a truly distinctive and luxurious appearance. The peg-effect skirt of this smart back zippered sheath features two deep pockets and a generous back kick pleat.

HORROCKSES COTTON—"minimum-iron"...superbly luxurious
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ABOVE STYLES IN SIZES 8 TO 18

B **RICHLY PLEATED**—A beautifully tailored sheath that achieves elegance through rich vertical bodice pleats that add extra dimension. The neat, spread collar which is artfully squared in the back may be worn open or closed. With slim center snap skirt featuring two pockets and a back kick pleat.

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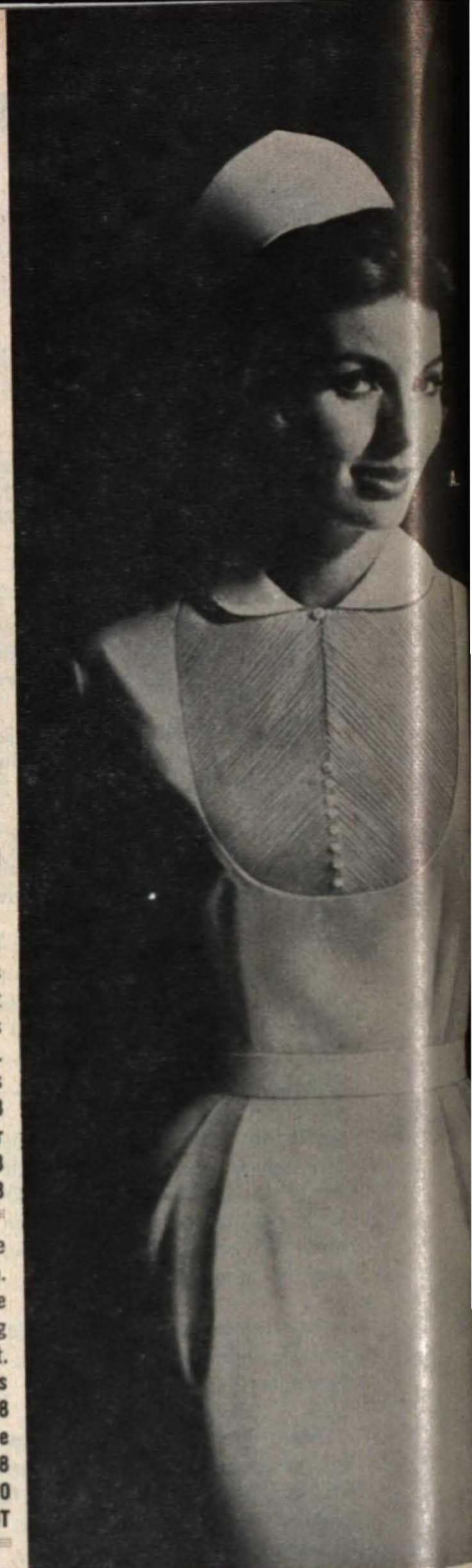
STYLE #0548—short sleeves—About $10.98
STYLE #4548—long sleeves—About $11.98
ABOVE STYLES IN SIZES 10 to 44



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Canadian Conference on Education

The second Canadian Conference on Education was held at the Queen Elizabeth Hotel, Montreal, March 4-8, 1962. More than 1,500 delegates attended. The conference had two principal aims:

To assure an exchange of ideas and information between the public and those responsible for the direction and encouragement of education at all levels in Canada;

To help create public understanding and support for the educational development which is essential to meet the needs of our growing nation.

The Canadian Nurses' Association was represented by HELEN M. CARPENTER, President; E. A. ELECTA MACLENNAN, First Vice-President; HAZEL B. KEELER, Second Vice-President; KATHERINE MACLAGGAN, Third Vice-President; SISTER MADELEINE OF JESUS, representative of the Nursing Sisterhoods; MARGARET E. KERR, Executive Director, *The Canadian Nurse;* M. PEARL STIVER, Executive Director, Canadian Nurses' Association; HELEN K. MUSSALLEM, Director of Special Studies and F. LILLIAN CAMPION, Director of the Project for Evaluation of Nursing Service.

Hamilton to the Fore

Hamilton was the first Ontario city to avail itself of the consultative advisory service in public health administration established by the Canadian Public Health Association.

TRENNA G. HUNTER, director of public health nursing for the Metropolitan Vancouver Health Committee, was given leave of absence to do the nursing section of a survey of the Hamilton health department. The study was requested by Dr. L. A. Clarke, medical officer of health. Miss Hunter, a past president of the Canadian Nurses' Association, is prominent in the public health field. She is the author of numerous articles on public health nursing.

The Hamilton survey sought to evaluate present health services in relation to changing needs. It covered all aspects of the health department of which the nursing program is an important feature. Special emphasis is placed on school nursing.

The consultant advisory service offered by the CPHA supplements similar services provided by federal and provincial health departments or by national health agencies.

Nursing Home Administration

The American Hospital Association in cooperation with the American Nursing Home Association and the American Medical Association is conducting an institute on Nursing Home Administration at the Seville Hotel, Miami Beach, Florida, March 27-29, 1962.

The institute will be devoted to the specifics of bringing the nursing home into the full scope of community health care. Applications should be mailed to:

American Hospital Association,
840 North Lake Shore Drive
Chicago 11, Illinois. Fee $40.00.

31st Biennial Convention

National Office is reaching the final stages in program planning for the Convention. We are exceedingly pleased with the number and calibre of the nurses who will be giving leader-

ship as well as their willingness to prepare themselves for their responsibilities.

Emphasis throughout the program will be on better nursing care and nursing education. The directors of the three special projects, the CNA School Improvement Program, the Evaluation of Nursing Service and the Study of Nursing Education in Canada, will present progress reports. It is expected that there will be some discussion of the Royal Commission on Health Services. Time will be devoted to survival planning for Canada with emphasis on health problems created by radioactive fall-out.

Mrs. JOYCE CAMPBELL is chairman of the RNABC Committee on Arrangements. This committee has been busy since last June, working on local arrangements for the business sessions and arranging hospitality for convention visitors. From a booth in the rotunda of the Auditorium information will be available concerning bus service, shopping, restaurants and places of entertainment. Sightseeing tours are being arranged so that visitors can see points of interest during the free afternoon and evening in the middle of the week. The Committee is determined to provide delegates with hospitality at least equal in warmth and interest to that experienced by B.C. nurses who have attended meetings in other part of Canada. This is no easy task, as those of you who have attended CNA biennial meetings in the past know.

The Greater Victoria District is arranging entertainment for anyone who would like to visit Victoria on the Saturday following the meetings. The highlight will be a tea in the gardens of Government House. There will be luncheons for special interest groups. Names of guest speakers will be announced later.

ANPQ Bridges the Gap

The insight of the nurses in the province of Quebec makes it possible for many French language schools of nursing, not only in Quebec but abroad, to benefit from their efforts. Based on their understanding of the great need for professional texts in the French language, the Association of Nurses has again put aside frustrations, cleared its vision and marshalled its energies to contribute to the advancement of nursing by translating another valuable nursing text. J. B. Lippincott Company has recently published the French version of the 11th edition of Eliason's Surgical Nursing by L. Kraeer Ferguson, A.B., M.D., F.A.C.S. and Lillian A. Sholtis, R.N., B.S., M.S. 765 pages.

Revised Hotel Rates

Reputedly due to the Seattle World's Fair, hotel rates on the West Coast have risen slightly since our listing of accommodation was published in January. Please check the revised list on page 250 before mailing your hotel reservation form to National Office.

(*Continued from page 227*)

Joseph's Hospital, Hamilton, died during 1961.

* * *

Margaret Jean (Tannahill) Rice who graduated from St. Andrew's Hospital, Midland, Ont. in 1929 died on December 1, 1961. She was a former superintendent of St. Andrew's Hospital.

* * *

Phyllis Margaret (Ayer) Ross who graduated from Moncton Hospital, N.B., in 1933 died on November 17, 1961. She had been employed as an office nurse.

* * *

Jean Marie Salon, a 1961 graduate of St. Joseph's Hospital, Victoria, died on November 15, 1961. She was on the staff of Nanaimo General Hospital, B.C. at the time of her death.

* * *

Edith Elizabeth (Scott) Sherritt, a 1909 graduate of Riverdale Hospital, Toronto, died December 11, 1961.

* * *

Laura D. Smith, a graduate from Columbia-Presbyterian Medical Center in 1932, died in New York on November 20, 1961. She was the senior editor of the *American Journal of Nursing,* having joined the staff in July 1951. Miss Smith served during World War II in France and England.

* * *

Annie Toomes who graduated from Montreal General Hospital in 1901 died on October 10, 1961.

NURSING PROFILES

Mother Georgette Leduc is the newly-appointed general superior of the Grey Nuns of Montreal. Born and educated in the province of Quebec, she is a graduate of Notre Dame Hospital, Montreal. Her post-basic nursing education includes a Bachelor of Science degree in Nursing Education from Marguerite d'Youville Institute and a Master's degree in Nursing Education from St. Louis University, St. Louis, Mo.

During 1940-52 Mother Leduc was director of nursing at St. Peter's General Hospital, New Brunswick, New Jersey, and for the next two years director of the school of nursing, St. Vincent's Hospital in Toledo, Ohio. In 1956 she returned to St. Peter's as Superior Administrator, a position she held until 1961 when she became Provincial Superior of the American Province of the Grey Nuns, Lexington, Mass.

MOTHER GEORGETTE LEDUC

She has been very active in nursing association work as an adviser for the Middlesex County Division of the Practical Nurse Association of New Jersey, a member of the nursing committee of the New Brunswick Civil Defense, a director-member of the Board of the New Jersey League of Nursing Education, a member of the public relations committee of Seton Hall University and the Council of the Conference of Catholic Schools of Nursing. She was also chairman of the committee on personnel policies for student nurses of the New Jersey League for Nursing and in 1957 became a member of the American College of Hospital Administrators.

RUTH GAW

The new director of nursing of Prince Edward Island Hospital, Charlottetown is **M. Ruth Gaw.** A graduate of the Hospital for Sick Children, Toronto, she received her early education in Quebec, Saskatchewan and Ontario. In 1946 she received a diploma in teaching and supervision from the McGill School for Graduate Nurses, completing requirements for her B.N. there in 1961.

From 1946 to 1950 Miss Gaw was assistant director of nursing and clinical instructor at the Queen Elizabeth Hospital of Montreal and for the past ten years has been director of nursing at the General Hospital, Guelph, Ontario. She saw service in England and the continent as a nursing sister with the R.C.A.M.C. from 1942-45.

She has been active with the ANPQ and more recently with the RNAO. In her leisure time she enjoys reading, the theatre and golfing.

Victoria Union Hospital in Prince Albert, Saskatchewan has a new director of nursing. **Katherine M. Scott** was born in Sabin, Minnesota and received her early edu-

cation in that State. She is a graduate of the Cook County Hospital school of nursing in Chicago and obtained her bachelor of arts degree from Hamline University in St. Paul. She did graduate work at the college of education of the University of Minnesota and at Northwestern University, Evanston, Illinois. She received an NLN scholarship to attend Chicago University for graduate study in nursing education.

KATHERINE SCOTT

Mrs. Scott has been director of nursing and nursing education at both the Grant Hospital, and the Englehart Hospital in Chicago. She has been an assistant professor at Ohio State University and director of nursing at Norton Memorial Infirmary, Louisville, Kentucky and at Assiniboia Union Hospital in Saskatchewan, and nursing arts instructor at Moose Jaw Union Hospital.

She has been active on NLN committees and ANA projects and is a member of the SRNA committee on nursing service. She is a member of the University Women's Club, enjoys travelling, reading historical novels and books on travel and collecting and trying out recipes.

Emily Neville has been appointed assistant director of the school of nursing, St. Clare's Mercy Hospital, St. John's, Newfoundland. A graduate of New Waterford (N.S.) General Hospital she worked as O.R. supervisor at the U.S. Naval Base Hospital, Argentia, Nfld., as a head nurse at Memorial Hospital for Cancer and Allied Diseases, NYC and O.R. nurse at Oak Ridge Hospital, Tennessee. For a time she did private nursing, returning to staff nursing at the New England Deaconess Hospital,

EMILY NEVILLE

Boston, from where she went to the Joslin Diabetic Clinic in the same city.

In 1952 she became a clinical instructor at St. Clare's, a position she held until her present appointment. She is a member of the education committee of the ARNN, president of the St. John's chapter and a member of the local branch of the Zonta Club.

Sister Mary Beatrice has been appointed teaching supervisor at St. Joseph's

SISTER MARY BEATRICE

Hospital, Victoria, B.C. Born and educated in Alberta, Sister received her bachelor of science in nursing from the College of St. Theresa and her master of science in nursing from St. Louis University. In addition she took a two-year course in Radiographic and X-ray Therapy Technique and holds diplomas from both the American and Canadian Registries of Radiological Technicians.

She has a broad background of experience in nursing education and service having been a staff nurse, instructor, director of nursing, and director of nursing education. She has served the RNABC as a member of the original curriculum committee, the committee on nursing education, and the board of examiners. At present she is a member of the executive of the RNABC and the Canadian Mental Health Association, B.C. division. Her special interests are gardening, flower arranging, playing the accordion, knitting and history.

HUMAN ADAPTATION

A Conceptual Approach To Understanding Patients

HARRY W. MARTIN, PH.D. *and* ARTHUR J. PRANGE, JR., M.D.

Innumerable varieties of stress play upon every individual at every stage of his life. How a person responds to this stress, the adaptations he is able to make, strongly influence his level of health. It is very important that nurses should be aware of these factors.

SOCIETAL CHANGE, changes in medicine, and man's effort to understand himself and his ills demand fundamental changes in nursing education and practice. If nursing expects or is expected to meet these demands, there may be a need for greater discriminative power in the profession between knowledge and techniques and a better balance in seeking knowledge on the one hand and of seeking techniques on the other. We are not suggesting that nursing will or should become a science of man, although there seems to be no reason why the profession should not make a contribution to knowledge about man's behavior-in-illness, particularly with respect to that behavior relevant to nursing functions. Precisely, we are suggesting that nursing needs a better conceptualization of its own functions and the human phenomena with which it deals. This path to better ways and techniques will be opened by ideas, not by discrete, poorly-related principles to be slavishly followed as techniques. In this connection we are reminded of what Galdston has said about medicine:

> Medicine is founded on, pursues, and cultivates the knowledge and understanding of man as a living creature whose being is framed by a world of many and varied realities. Medicine is not only a body of knowledge and skills which aims at benefiting man, but also an understanding of the nature of the universe, and of man's position in it.[1]

It is our impression, based upon several years of work with nursing, that many nurses dichotomize man into entities — physical and psychological. This division appears to stem from the ancient but still prevalent separation between mind and body. Such thinking, of course, is not unique to nursing; indeed, its presence in nurs-

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ing may be partly accounted for by its continued existence in medicine. Nevertheless, patients tend to be seen as either physically sick or emotionally sick. That physical and psychological functioning are a unity in any patient, certain cliches notwithstanding, is often not accepted. The implication that sickness may have an emotional base is somehow reproachful. Nursing care fails to become a unity: the elements of care become an "either — or" matter. Patients are either physically or emotionally sick; nurses are often "too busy giving physical care to give emotional care" or "emotional care takes too much time."

How can these deficits be overcome? What seems needed is a conceptual model by which the nurse can order her thinking and acting. Such a framework, if successful, should not impose an artificial integration on nursing curricula. It should allow the various aspects of present curricula to fall into a series of natural relationships. Such a series of relationships, in fact, would help satisfy that elusive curricula goal, integration. But this in itself would be a pallid recommendation, for any such framework has done less than half the job unless it also has implications for practice. In the case of nursing, it should provide clues for improvement of patient care.

In this paper we propose such a scheme which, if properly employed, may be of considerable use to nursing. It is not a new creation on our part.[2] It is not social science, nor is it psychiatry, but a way of looking at man that has evolved from insights gained from these and other disciplines.

The Adaptation Frame of Reference

Where the work of a profession demands utilization of knowledge from several disciplines, it is often desirable, if not imperative, to have certain assumptions and conceptual understandings which lend some logical unity to what may appear as a collection of diverse and unrelated ideas. In the case of nursing, three questions are pertinent in this regard:

1. Is there a conceptual scheme which at least approaches a unifying view of human biological, psychological, and social functioning?
2. In what respect are individuals truly individuals — that is, in a technical sense, for facilitating nursing care?
3. How can loosely-related information on patients be comprehended in a meaningful and useful whole?

The idea of human adaptation answers these questions rather adequately. Broadly conceived, it comprehends all those disciplines devoted to the scientific study of human behavior. By *adaptation* is meant all conscious and unconscious forms of adjustment to actual or supposed environmental conditions — past, present, and future — which confront man. *Environment* consists of both that which is exterior and interior to man; man and environment are not solely juxtaposed entities in conflict, but also a single, unified process, although this process is rarely completely harmonious.

Foci of Human Adaptation

The preceding paragraph suggests the concept of stress. Before discussing stress in more specific terms, it will be helpful to outline the principal areas in which adaptation must take place since they are sources of stress. *Figure 1* illustrates a concept of man as a process in and with environment.[3] With exterior environmental phenomena represented broadly as physical, psychological, and sociocultural, the circle represents man as an entity, and in his entirety,[4] as composed of cellular "C", psychological "P", and social elements "S" which are linked with counterparts in the exterior environment. The dynamic relationship among these is symbolized by dual-directional arrows within the circle; the interchange between the interior and exterior is similarly denoted by arrows intersecting the circle.

At the cellular level the human organism functions as a complex biochemical process. Adaptation here requires ingestion and assimilation of compatible substances, excretion of waste, protection from destructive or damaging forces whatever their source. Species survival requires procreative ability and opportunity. Medicine, in its narrowest, traditional definition, is concerned with the problems of human maladaptation at this level, that is, with pathological conditions in the structure and function of the organism.

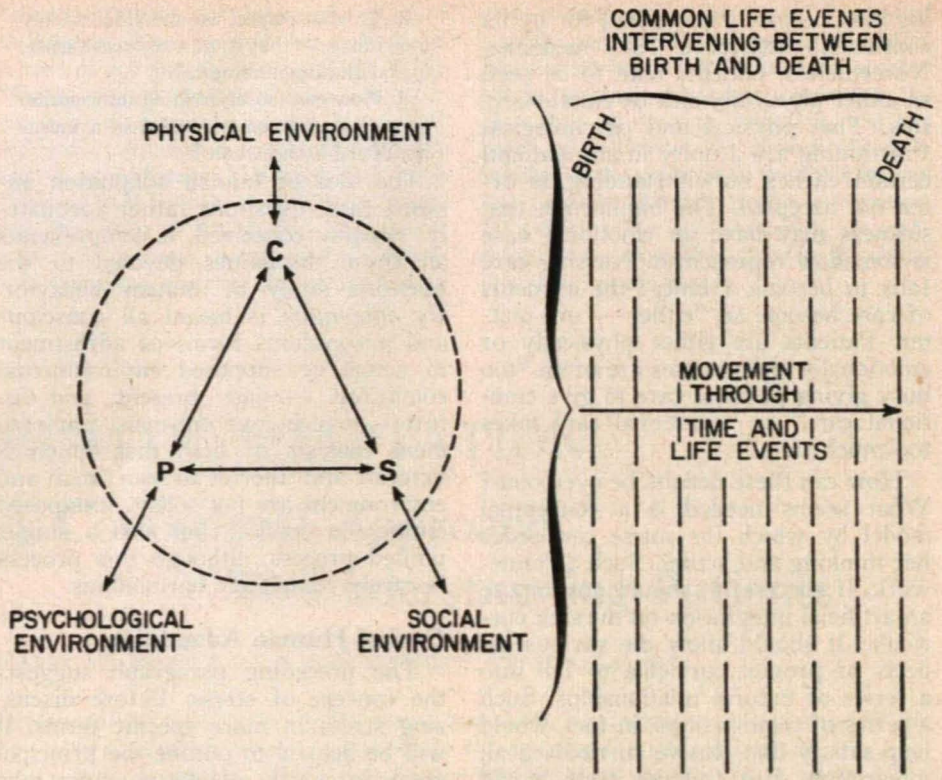

Figure 1. *The circle and its content represent the individual, whose environment consists of both the space surrounding and occupied by him. Interaction between the individual and his environment (i.e., the inner and outer environment) is denoted by the breaks in the circle and the dual-directional arrows intersecting the circle. Movement of the individual through time and life events are depicted to the right of the parenthesis; as the individual proceeds through life he encounters events and situations to which he must adapt. The process and modes of adaptation to these conditions result in more or less successful consequences for the individual which, in turn, can be more or less stress reducing or stress producing.*

Rooted in the cellular substrate of the organism are neurochemical processes and mechanisms that energize the organism and mediate between exterior and interior environment. Man's psychological nature is based on this substrate and is comprehended in such concepts as: mind, ideation, learning, perception, conscious and unconscious processes. At this level, it has been psychology and psychiatry that have sought to understand the integration and function of these processes.

The third level is in the social or, more accurately, the sociocultural sphere. Patterned, relatively permanent modes of human behavior in groups, inter-individual interaction, values, beliefs, norms, symbols become the forms of attention. Man's culture, in addition to these elements, contains artifacts with instrumental and expressive functions which have evolved in the process of adaptation. The importance of these lies in the fact that beyond their utilitarian value they become invested with meanings which play a crucial role in man's adaptive process. Understanding man from the point of view of his social and cultural heritage has been primarily the task of the sociologist and the anthropologist.

These three levels — cellular, psychological, social — though often looked upon as separate facets of human existence, may be viewed in their aggregate as one system composed of three interdependent sub-systems. The adaptation frame of reference holds

that if a total view of man is to be approached, it is necessary to have some comprehension of each of the three sub-systems and of the relations among them. The interdependence among them is vastly more complex than examples reveal; however, three examples serve to exemplify their effect upon one another.

> An individual attacked by a paralytic polio virus may suffer permanent damage that restricts his mobility and disfigures his body. In one respect all this is simply cellular, but much more is involved if one is concerned with the total individual. He must be cared for by others; the residual effect of his disease will limit, according to the amount of damage, his participation in society for the remainder of his life. Psychologically, the individual has to adjust to these changes and deficits by acquiring a different concept of himself.
>
> Suicide affords another rather obvious example. An individual, meeting with failure in business or romance, may succumb psychologically and seek solution by suicidal measures that may destroy his life or damage his body.
>
> A social situation such as giving a public address may have special (symbolic) psychological meaning for an individual so that he reacts with anxiety, one physiological correlate of which may be overbreathing. In this process, carbon dioxide is lost from the body at an excessive rate; this, in turn, might alter the chemical reaction of his blood to such an extent as to cause death were it not for the activity of elaborate chemical systems which react in a manner to preserve the slight alkalinity of the blood within a very narrow range. Thus, a stress created by a social situation because of special psychological meaning, may evoke a chain of cellular adaptations, all with minimal awareness on the part of the person involved.

Health, Illness, and Stress

It is now pertinent to examine the concepts of health, illness, and stress.[5] Romano designates health and illness as:

> . . . phases of life, dependent at any time on the balance maintained by devices, genically and experientially determined, intent on fulfilling needs and on adapting to and mastering stresses as they arise within the organism or from without.[6]

Health, then, represents a "successful" adjustment, and illness a failure of adjustment. Engel says with regard to this formulation:

> Clearly, health and disease are relative concepts, so that at times no clear distinction between the two is possible. This formulation takes into account the process of existing between and within the total organism and the total environment. The needs of the organism have a biologically determined source in instinctual energy, but satisfaction of the needs is achieved through biological, psychological, and social devices. The aim is to maintain a condition of stable, dynamic equilibrium between the internal and external environments.[7]

What constitutes stress? Stress may be:

> . . . any influence, whether it arises from the internal environment or from the external environment, which interferes with the satisfaction of basic needs or which disturbs or threatens to disturb the stable equilibrium.
>
> Further, as Jennings demonstrated in the most simple living organisms, whether or not a situation is stressful depends upon the organism's past history, genically and experientially determined.[8]

Stress, then, arises from interference or assaults, threats of assaults, real or supposed, from without and from within. Attacks may come from other men, animals, parasites, or noxious agents of various forms. Factors threatening survival or satisfaction of basic or derived needs may arise from natural or man-made forces. Overdemanding or conflicting social and cultural expectations may come from one's participation in the institutionalized foci of human behavior, for example: courtship, family, work, religion, and so on. Deprivational interference may arise from: inadequate metabolic supplies, failure to meet social expectations and aspirations, loss of love, or security. Other sources of stress not frequently recognized come from unacceptable needs that have been repressed but which interfere with the adaptive process.

Because of man's nature, stress does not necessarily or always have an objective basis in reality. It may be provoked by *threats* and *symbols* of danger and deprivation as well as by *actual* danger or deprivation. Stress of this type is frequently insidious and as damaging as that from more concrete

sources. Magnitude and time are important aspects. Engel says:

> . . . in addition, stress must be considered in a quantitative sense, taking into account both the magnitude and the time curve. How much, how suddenly, and for how long are important variables.[9]

It should be pointed out, however, that stress is difficult to define in measurable terms.[10] Measurement of how much stress a particular individual can endure, at least outside of experimental situations, has not yet been achieved. Capacity to resist or endure stress varies from person to person; what may constitute stress for one person may not be for another. Regardless of these problems, the concept is useful for advancing comprehension of human adaptation. In using the concept it is imperative that thinking in merely quantitative terms be avoided. What is important is the *meaning that stress has for an individual and how he deals with it.*

Human Needs and Stress

Needs may be classified in two groups:

(1) *Basic needs,* that is, those intrinsic to the organism, some of which change or develop through biological maturation;

(2) *derived needs* or those which arise from socialization and through interaction with the exterior environment.

Some derived needs, although having external origins, rest upon the internal environmental potential of the organism. The sex urge (need, drive, or instinct), for example, is organically based, but internalized social values and norms create needs which control expression and satisfaction of the sex urge in socially prescribed ways. Stress, then, may be generated by conflict among basic needs, between basic and derived needs, or by incompatibilities and contradictions between and among derived needs.

Adaptive Techniques

Meeting his needs and adapting to the stress which confronts him in life, the individual, including his body, resorts to various measures — physiological, psychological, social — which tend to maintain a relatively stable balance within and among the various systemic parts. This balance is referred to as *equilibrium or homeostasis.* Homeostatic devices or techniques are regulatory mechanisms and compensatory reactions in any system of organized, interdependent parts. They tend to establish a balance among parts, resist imbalancing factors, restore balance, or re-establish a relatively stable relationship at some other level. This point cannot be overemphasized, for the maintenance of health, and sometimes of life itself, depends upon the preservation of certain conditions — cellular, psychological, and sociological — within rather narrow limits. Adaptive techniques are facets of the equilibrating process involved in this unending struggle. No attempt will be made to enumerate techniques available at the various levels where equilibrium must be maintained; instead, we shall suggest general modes and forms that may occur.[11] It must be understood that the adaptive efforts of a given individual are not merely a matter of his present situation. They are partly determined by his particular genic structure and past individual and sociocultural experiences, all of which may foster certain responses and inhibit others.

Mobility (including motility and flexibility) is possible for the individual in physical, psychological, and social space. This allows withdrawal or approach, association or disassociation, retreat, defence, or attack as means of dealing with stress and assuring equilibrium. Closely related to mobility is the potential of *rearrangement* of systemic parts and use of alternative functions as an adaptive manoeuvre. Rearrangement may occur by voluntary or involuntary action which may prove to be functional or dysfunctional. For example, at the organic level, encystment, allergic reactions, or blood-cell reaction to infection may take place. Certain psychological mechanisms are necessary for "normal" functioning, but an individual may come to rely upon some mechanisms more than others as a means of maintaining psychological equilibrium, for example, projection. This mechanism, which has the function of locating some of one's own attitudes as being resident outside one's self, may be useful to a degree, but may impose secondary problems by seriously distorting reality.

Attempts to adapt can bring into play the principles of *inertia* and *economy* which do not involve new methods but result in the use of old techniques in new situations. In relying on these principles the individual consciously or unconsciously resorts to methods that have been successful in solving bygone problems, though they may or may not be appropriate to the current situation. Adaptive techniques are aimed at re-establishing a balance but the very act of adaptive effort may be stressful to varying degrees, and bring into play new forces which have to be integrated. Childbirth may satisfy the drive toward motherhood but raises the problems of child-rearing. Too much "success" may be as stressful as not enough; the *nouveau riche* may be able to purchase the symbols of their newly acquired economic status but find themselves snubbed by those with whom they wish to associate.

Useful adaptive techniques when excessively or inappropriately applied lead to maladaptive consequences. A little alcohol before dinner may reduce tension, but too much used too often may lead to social complications or liver damage. In a similar way, on the cellular level a wound can *overheal* — a scar becomes a keloid, a type of disfiguring tumor. In man, these complications are compounded because of his penchant for symbolization. Some symbols, such as stop signs, are generally agreed upon, but others are highly private. Thus, the adaptive problem is not always what an observer understands it to be on first glance. To state a common example: If a patient scrupulously avoids riding elevators, this bit of behavior may represent an unconscious conflict, and adaptive problem, that cannot be elucidated without more information.

Limitations on Adaptation

The range of adaptive modes, though extensive, is relatively determinate.[12] Organically, the individual's spectrum of adaptive responses is limited by morphology, and physiochemical structure. As Engel says in paraphrasing a statement of H. S. Jennings, "A cornered amoeba cannot escape by flying."[13] Similarly, at the social level the individual is bound by a finite, yet large number of solutions. There is *perhaps* greater latitude here than at the organic level for creation of new adaptive modes. However, in many instances, inertia and tradition forestall development of new solutions, produce distrust of these, and tend to define them as deviate, particularly if they contradict old values. Limitations upon psychological adaptation depend upon the quality of the individual's psychological heredity and upon previous experience with important figures that continue to operate by unconscious representation. Finally, the concept of adaptation is not an exclusive means of understanding all processes which the individual undergoes. However, it is useful for understanding the relationships between an individual and his environment, both internal and external. It is especially useful in taking a comprehensive view of illness.

The Life Cycle and Adaptation

Within certain limits, the adaptive tasks facing an individual at any period of life can be anticipated on the basis of relatively little information. By noting only the age and sex of an individual it is possible to predict fairly accurately the general nature of many changes which he is undergoing. As more specific information becomes available, understanding and assessment of the nature and force of stress increase in accuracy. The concept of adaptation employed in conjunction with that of the life cycle can be most useful for identifying stress areas in a given individual.

Although the process of adaptation proceeds minute by minute, from conception to death, it characteristically passes through several phases or epochs usually introduced by critical life events. *Figure 2* extends *Figure 1* by depicting the individual as moving through time and encountering typical life events designated as nodal points. These events are conceived as introducing successive epochs or phases over the life span which are outlined by the broken vertical lines extending downward from the nodal points. Although some epochs are introduced abruptly, there are periods of anticipation and transition. Obviously, some people do not follow the typical course

through the life cycle. Some move faster or slower than the usual rate and thus have an atypical course — that is, out of phase with the usual pattern. At any time the cycle may be disrupted by accidents or illness, and death may end the cycle for an individual at any time.

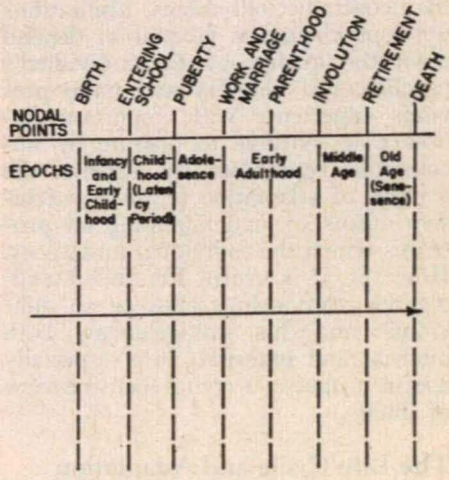

Figure 2 *expands the right side of Figure 1 to illustrate some common life events (nodal points) and the various stages (epochs) through which individuals pass in the course of the life cycle. The nodal points, for the most part, are commonly encountered events which more or less introduce the several life epochs. The vertical lines suggest the existence of boundaries between the various epochs; however, by being broken the lines imply that epochs overlap. And, although the lines separating the various epochs are equidistant, it is not meant to suggest that all epochs are of equal duration.*

As individuals move through the life cycle they are faced with a series of changing conditions — physical, social, and psychological. New definitions and concepts of self must be acquired with respect to one's age, sex, and other factors specifying expectations of the individual. Such adjustments tend to be focalized around outstanding life events. It is at these nodal points, at these times of adaptive crisis, that adaptation is most likely to fail and illness to occur. This can happen in highly specific ways but the governing principle is simply stated. Each nodal point requires the employment of new adaptive techniques or the extension of old ones, and these techniques, or their relative lack, may fail in their purpose.

Such an outcome is especially likely if the crisis is sudden or if the individual is poorly prepared for it on the basis of past experience. That is, each experience partly determines the individual's ability and manner of meeting the stress of subsequent situations. To cite a common example:

> If a girl has had no sexual instruction or has been raised in a social atmosphere of sexual mystery, she will experience relatively greater stress and have fewer means of coping with the onset of puberty and menstruation. If other necessary biological factors are operative, she is more likely than another pubescent girl to suffer acne or dysmenorrhea. Later, all this experience and her psychological elaboration of it partly shape her behavior in courtship, marriage, and childbirth and her means of managing these events.

Of course, under usual conditions each nodal point in the life cycle is the occasion for growth and development and for the enrichment of life. It is when the individual is unprepared or unable to accept the change that adaptive failure occurs; when the change is too sudden, too severe, or ill-timed, illness is likely to result.[14] Let us now, in suggestive fashion, examine several other adaptive problems associated with the life cycle.

The working phase of life and its closure through retirement illustrates an order of adaptive tasks. For most men — and a increasing number of women[15] — work presents a long range and sometimes acute adaptive problem. The concept of work is subject to differing cultural influences. At one time or another, and at one place or another, work has been viewed as a necessary evil, as a means of attaining righteousness, as evidence of personal integrity, or as punishment for Adam's having sinned. Thus, an individual's social and cultural background determines, in great part, the feelings he has about work in general and his own job in particular.

Work may be dangerous, as for example, through exposure to radiation or silicon dust. A man's work, which accounts for much of his working life, can afford him much satisfaction or present him with chronic or acute stressful situations. Ambition, a lack

of it, ability to do the job, promotions, relationships with fellow-workers, and relationships with superiors have their stress potential. It may be that a relationship with the boss, reminiscent of the child-father relationship, is an important element in the worker's adaptation (and possibly that of the boss). If the relationship is disrupted for any reason, an adaptive crisis can be precipitated.

That it is not merely the event but also the *meaning* of the event that determines behavior cannot be overemphasized. Perhaps it will become clear if we point out that, regarding work, success as well as failure can produce adaptive crisis. For example, promotion may arouse guilt. To understand this, one needs to understand the life history of the individual, and to direct attention to his unresolved competitive feelings toward his father and guilt feelings for becoming "better," that is, being promoted. It is worse than useless to think, concerning a patient, "What is he so upset for? He just got promoted!" One must try to understand the *patient's feelings* as they exist; then the *meaning* of events may become clearer.

The working life of a person comes to a close with retirement. Beyond the fact that most persons do not retire on an income sufficient to meet their needs there are dysfunctional socio-psychological consequences that have strong implications for survival. Most of us know of at least one individual, in relatively good health who, upon retirement followed a downhill course to demise. The time when one will be deposed from his job approaches inexorably. It can be anticipated with anxiety, apprehension, and feelings of loss of self-esteem. Persons who have invested the major part of their lifetime in a job frequently find it difficult to give it up. It often means forfeiture of authority, responsibility, friends, and other meaningful social contacts associated with work. Above all, it says, in effect, "You are no longer useful in the job or to society," and clearly portends the final phase of life. Following retirement, one has to adjust to a new schedule of daily rounds of activity — in a sense, inactivity. From a comprehensive point of view these problems are as much a part of health care of individuals as organic pathology. Indeed, stress deriving from either work or retirement can become an integral part of the clinical problems of people.

Another common area of concern in adult life is the dissolution of the family by departure of children from the home. Significantly, this occurs around the involutional period of parents. When a son or daughter leaves home for reasons which, on the surface, may be cause for rejoicing, the departure may create feelings of loss. Marriages are usually considered happy occasions but they are often — facetiously — compared to funerals. Weeping parents at marriage ceremonies are not uncommon. Tears of joy on these occasions may be mingled with those of sorrow. Most parents adjust to the loss; with some, the feelings of loss persist and may deepen into depression.

> The father of five children was admitted to hospital for the sudden onset of severe pain associated with cervical osteoarthritis. He gave evidence of considerable depression and, as he described it, "a filling up with emotion." Four years before the onset of symptoms his father had died; two years later, a daughter had married. One Sunday afternoon his eldest and favorite daughter informed the family that she had become engaged. That same day the patient's symptoms began.
>
> Since osteoarthritis is a slowly progressive disorder, the structural changes in this man's spine presumably were present for some time, yet he had no symptoms until stressed in another way as well. Later the patient said that the daughter and her mother had "talked about the marriage a great deal around the house." He had not discussed it with anyone; he felt it would be too upsetting.

Separation, or loss, is often a crucial factor in adaptive breakdown. Underlying this observation is the fact that human beings, as compared to other organisms, are highly related to each other and that intense interrelatedness, in most cases, is necessary for the maintenance of health. These facts are shown by conditions of natural and experimental isolation, which regularly result in psychotic-like states. Separation from significant individuals can occur at any time, as by death; it can also occur in less ob-

vious, that is, more symbolic ways, as by the marriage of a favorite child. Even the threat of loss can exert profound effects. Moreover, once hospitalization has occurred, the patient is always, at least secondarily and partially, separated from those most important to him, a point of practical clinical significance.

The importance of separation as a factor in psychosomatic illness has been discussed by Shands[16] and others. It has been corroborated and expanded as regards general medical patients by Schmale.[17] Neither these authors nor we suggest that separation is always antecedent to illness. Nevertheless, our understanding of a sick person can often be deepened by examining this possibility. This examination, in turn, is aided by a review of the patient's current adaptive problems. These problems in some measure correspond to his place or level in the life cycle.

A universal problem of separation is presented by the death of a loved one. *Figure 2* places death at the end of a full cycle; obviously, however, it can occur at any time. The time at which it does occur is of crucial importance; it makes considerable difference whether one's parents die when one is six or sixty. Normally, such an event is followed by a period of grieving. This is really a symbolic means of *gradually* detaching oneself from the loved person. Sometimes, for subjective or objective reasons, the process is thwarted. In such instances adaptive breakdown is likely to occur.

> Separation reactions in the healthy person are characteristically accompanied by expression of grieving, but the possibilities for vicious circle mechanisms are very quickly apparent here when we consider the difficulties which are related to this process. In the first place, the act of grieving is itself painful and there is a conflict between it and the tendency to avoid pain. In the second place, grieving is an emotional expression which takes place most easily in the presence of a kindly disposed listener. Here again the process is complicated because the listener, the companion, is frequently himself distressed by the grief of the bereaved person. In order to preserve the relationship to the companion, the bereaved person must frequently suppress some or all of the manifestations of grief . . . There are cultural factors of great importance in the degree to which emotional expression is approved or disapproved. In this country, and particularly in sections where the Puritan tradition is strong, there is a tendency to disapprove of the expression of feeling and to set the stiff upper lip as a sort of ideal.[18]

If the nurse is aware of this process, she may very well serve as the nondistressed, "kindly disposed listener." She may arrest and even partially reverse the chain of events which often proceeds from thwarted grief to guilt and depression and to illness.

Conclusion

In this paper we have indicated some factors that point to the need for a comprehensive framework within which the nurse may view the phenomena of health and illness and within which she may organize the diverse phenomena that confront her. We have suggested a framework that has gradually evolved within medicine and has been enhanced by other disciplines. At any given time, in applying this concept to a given patient, the nurse should consider the position of the patient in his life cycle. This will give clues as to likely problems of adaptation and likely adaptive attempts. This broad framework and its application should confer broader understanding. If this is so, the nurse is in a better position to help create and maintain an atmosphere in which the recovery of her patient is promoted.

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1. Iago Galdston, editor, *Beyond the Germ Theory*. New York: Health Education Council, 1954, p. 6.

2. The sources of this framework and the ideas contained herein are many. We are most directly indebted to the essay by George L. Engel, "Homeostasis, Behavioral Adjustment and the Concept of Health and Disease," in Roy L. Grinker, editor, *Mid-Century Psychiatry*. Springfield, Illinois: Charles C. Thomas, Publisher, 1953, pp. 33-59.

3. Leo W. Simmons and Harold G. Wolff, *Social Science in Medicine*. New York: Russell Sage Foundation, 1954, chapter 3.

4. A question may arise regarding

omission of reference to the religious or spiritual factor. Religion, insofar as it is an institutionalized form of human life, may be considered as psychocultural phenomena and is thus included in this frame of reference.

5. The links between stress and disease are extensively discussed by Simmons and Wolff, *op. cit.*, chapter 5.

6. As quoted by Engel, *op. cit.*, p. 33.

7. *Loc. cit.*

8. *Ibid.*, pp. 51-52.

9. *Ibid.*, p. 52.

10. William Caudill, *Effects of Social and Cultural Stress in Reactions to Stress*, Pamphlet 14, Social Science Research Council, New York, 1958, pp. 1-10.

11. Engel, *op. cit.*, p. 41.

12. Simmons and Wolff, *op. cit.*, pp. 165-167.

13. Engel, *op. cit.*, p. 41.

14. It is true that in some instances illness may not represent only a failure of adaptation; it may also represent the adaptive attempt itself. In an example cited, a keloid, an over-reaction to tissue injury, is evidence not only of adaptation gone wrong, but also of the adaptive attempt having been made. In this sense, maladaptation does not *cause* a disease — a disease *is* a maladaptation.

15. Working women, because of many social attitudes and implications of why they work, are confronted with some problems quite different from those met by men.

16. Harley C. Shands, "Problems of Separation in the Etiology of Psychosomatic Disease" *Bulletin of the Muscogee County Medical Society*, Vol. 1, August, 1954, pp. 9-19.

17. Arthur H. Schmale, Jr., "Relationship of Separation and Depression to Disease" *Psychosomatic Medicine*, XX July - August 1958, pp. 259-277.

18. Shands, *op. cit.*, p. 15.

In the foreword of *Spotlight on Nursing Education* appears the following statement made by the immediate past president of the Canadian Nurses' Association:

> A profession such as nursing which seeks, by its service, to earn the confidence and approval of the society it serves, assumes also the responsibility of maintaining that service at the highest possible levels of competence and effectiveness. — ALICE GIRARD

In approaches toward the above-stated objectives, the programs in nursing aided by the W. K. Kellogg Foundation have given particular emphasis to the educative aspects of the profession's efforts. The nursing programs in Canada currently aided by the Foundation's Division of Nursing represent a variety of activities and include assistance to the following:

The *University of Saskatchewan* — for a program in nursing service administration, including an in-service education project for the nursing service personnel in the University Hospital.

The *University of New Brunswick* — for the development of a pre-service curriculum in nursing leading to the baccalaureate degree, and a job-related continuing-education program for nurses in the regional area served by the school.

The Canadian Nurses' Association and the Canadian Hospital Association — for a *correspondence-extension course for nursing unit administrators.*

McGill University — for the inauguration of a nursing education program leading to the master's degree, to prepare nurses for leadership positions in teaching, administration and supervision.

The *University of Western Ontario* — for the establishment of a curriculum at the graduate level to prepare directors of hospital nursing services.

— *Annual Report 1961*, W. K. Kellogg Foundation.

* * *

Canada's 18th National Health Week is being held this year March 11-17. The Health League of Canada is sponsoring the first session of the Canadian Health Forum for three days of the week.

The subjects proposed for panel discussions are: Preventive medicine, world health, geriatrics and gerontology and ways to improve communications. Several prominent personalities have been invited to speak at the Forum: Honorable Hubert Humphreys, chief whip of the U.S. senate and foremost exponent of the idea of world health supported by voluntary action; Right Honorable John Diefenbaker; Dr. Paul Dudley White, well-known heart specialist; Dr. H. S. Gear, secretary of the World Medical Association and Dr. Harvey Adams, president of the Canadian Public Relations Society.

The Role of the Nurse in a Changing Society

JEAN-C. FALARDEAU

This address was given at the Annual Meeting of the Association of Nurses of the Province of Quebec, in November, 1961.

I. SOCIETY IS REFLECTED in its institutions. It has seemed to me for some time that one of the institutions in which North American society is reflected most vividly is the hospital. It is the arena where the forces of disintegration and human efforts of conservation confront each other in the combat for life and death. Here the two great dramas of human life, birth and death, are played. Here society concentrates the best of its technical resources, its inventions and its human brains. In more than one way, the hospital constitutes a miniature replica of our whole society.

The hospital also resembles the labyrinthine village in which the action of Kafka's novel, *The Castle,* takes place. Who can forget this mysterious village where we are taken on adventures with the no less mysterious "Mister K"? A person without identity, surrounded by strangers, searching for a personal label, an occupation, a home, roots — in a word, for an identity, in a community without meaning, save that which comes to him from his relation with an enigmatic beyond, with this disconcerting "castle" which, in the haze, dominates the village and where reside those from whom the orders come and on whom depend the collective and individual destinies of the inhabitants of the village.

I imagine that a large number of those who have visited a modern hospital as patients have experienced a similar feeling. You recall the first impressions of Gabrielle Roy's *Alexandre Chenevert (The Cashier)* when he entered the hospital.

> . . . The rattle of typewriters greeted him. In the distance, a telephone was ringing, which no one seemed in a hurry to answer. People were flitting back and forth along the corridors. When you first arrived, the hospital was not too unlike a business office: a counter, notices, an information desk, and even what looked very much like a wicket . . . He was confronted with paper and ink. Here as everywhere else, the first thing you had to do was fill out forms.

From these observations one can assess some characteristic features of the hospital: a bureaucratic type of world where social relationships are impersonal to the point of anonymity; where individuals take notice of each other exclusively through well-defined roles — those of doctor, specialist, patient, nurse, technician. A world, too, in which a minute division of labor is made in the most "rational" way possible and according to an imperious hierarchy of responsibilities and regulations.

By the very nature of its origins, the hospital had to have an authoritarian structure. A little like the army, it was a place where life and death vied with each other, where it was imperative for the individuals who made up its ranks to be rigorously subordinated one to the other, under the unquestioned command of those who were "masters after God." Today's hospital, however, is not a place where one goes for the sole purpose of dying. Rather, one goes to obtain an "inventory" of health. One goes for elective surgery, examinations, check-ups, or only for a rest. The hospital no longer has the tragic character it once had. Without being a place of organized leisure, it is becoming more and more an oasis for the pause that refreshes. Furthermore, programs of health insurance and hospital insurance have directed toward the hospital people of all ages, all geographic and ethnic origins, all social classes. It has become a mass institution. It is not unlike industry which uses progressive technology for the mass production of goods and services which are destined for the largest possible number of consumers.

The hospital is an enterprise whose technicians are supplying medical services to an indefinitely extensive and undifferentiated public.

II. Through her professional occupation, the nurse occupies a key position among those technicians of the hospital enterprise. Because of her daily contact with chain production, with bureaucratic red-tape and with the anonymous structure of power and authority, and, above all, because of her relations with the patients, she is in a vantage position to observe changes in collective attitudes and behavior.

I would be curious to know what is the nurse's image of the contemporary hospital patient. I would be very surprised if the most significant trait of this image was not determined by the fact that the "average" patient is now far removed from his rural origin, that his needs and tastes for material comforts have increased, and that he displays many whims. As David Reisman has noticed, our society now produces individuals who are more and more "other-directed." Each tries to live and think like his neighbors, like his occupational colleagues, like the social class to which he belongs or aspires to belong. The movies, television, and publicity have popularized standard ideas of status and prestige to which most people try to conform. Poorly integrated into a changing society, they are worried about their status. Uncertain of their identity, concerned about being well-thought of, they exaggerate their accomplishments to attract attention. Hence, their display of symbols of social success. The individual thinks highly of himself and expects to be given still more recognition. Whether he is at a resort, at a restaurant or in the hospital, he surrounds himself with such status symbols as he deems useful to strengthen his uneasy social personality.

This socially mobile "average" patient also thinks that he possesses a vast amount of medical and scientific knowledge. Living in a world where advertising informs him daily of the conquests of science, in a world where, in order to create any interest, a food, a new remedy or an opinion must be reputed to be "scientific," modern man wants to be informed objectively about everything that touches his existence, and particularly his health. He is, however, only a man of "digest" science. His medico-pharmacological background includes an impressive vocabulary of beneficent terms, such as "antibiotic," "vitamin," "Metrecal," as well as a black list of nightmare concepts such as, "cholesterol," "thrombosis," "cancer." If he belongs to a class which claims to be more sophisticated, he has a whole arsenal of psychoanalytical terms on the tip of his tongue when he enumerates his illnesses or those of his friend. He will understand the etiology of his child's bronchitis or his own arthritis only if they are spoken of in terms of complexes or of traumas of the Ego.

I am obviously oversimplifying. In any case, my point is that the contemporary patient expects to be informed, in the most "scientific" way possible, about the illnesses he has or believes he has. He fancies that he is now freed from the beliefs of folklore that were held by his grandparents. Unconscious of the fact that he has substituted traditional folklore for another type which is no less mythical, he wants to be identified with the stereotype of the "informed citizen" of our era: a rational man, informed about everything, critical, competent to judge the technical efficiency of those with whom he deals — either his garageman, his electrician, his doctor, or the latter's assistant, the nurse.

III. This is only one among many of the expectations that patients hold about nurses. The variety of these expectations varies according to whether the patient is a man or a woman. However, these brief considerations about the hospital and the patient are sufficient to indicate in what ways the contemporary nurse's role is being modified.

The practice of any professional activity occurs within a web of social relationships with categories of individuals who, themselves, play various specific roles. The teacher, for instance, is in relationship with: his pupils; his colleagues and his superiors in the hierarchy; the members of a school board; and his pupils' parents. Within the bureaucratic structure of

the hospital, the nurse's activities are carried out in a vast web of relationships which include: the patients and their relatives; her colleagues — graduates or students; the heads of departments; the doctors and their assistants; laboratory technicians; social workers; the personnel manager; the business office personnel, etc. No matter how heterogeneous this web, it seems that the nurse's essential relationship is the one which relates her to the doctor and the patient. This intermediary responsibility is not of recent origin. A Sanskrit treatise of 3000 years ago states:

> The doctor, the remedy, the nurse and the patient are an aggregate of four elements. It is a question of knowing which virtues each must possess to bring about the healing of patients.

The patterns of the doctor-nurse relationship are manifold. Apart from the fact that medical specialities are multiplying indefinitely, the division of labor and responsibilities between the various kinds of doctors within the hospital is becoming more and more strict. The nurse is in contact with each of these categories. She must be able to understand and interpret the technical language of each of them as though she were one of them. Further, it is expected that she will act like a expert-colleague of the specialist. Accordingly, she should possess a variety of scientific knowledge which far surpasses the medical knowledge that she was exposed to during her brief professional education. On the other hand, her status remains rigorously subordinate to that of the physician. Regardless of the nuances that differentiate the respective statuses of the medical specialties, all the doctors in the hospital share the same global status of prestige and authority. They hold the effective power to give orders, yet, their presence in the hospital is episodical while that of the nurses is continuous. The doctor is *in* the hospital without being completely *of* the hospital, hence, a frequent occasion for friction if not resentment on the part of the hospital personnel. Those that are invested with the highest authority, the doctors, are not those on whom the most onerous load of responsibility rests, the nurses.[1]

Another paradox confronts the nurse, this time in her relationship with the patients. It is no longer a question of an imbalance between status and responsibility, but between an ideal of service and the concrete conditions of professional practice. If the nurse, in principle, desires to give to each individual patient as much time and attention as his status as a patient requires, she finds that, in practice, it is less and less possible to realize this ideal. The over-populating of hospitals and mass services, mentioned previously, are such that patients are reduced to the state of "cases." The nurse does not have time to know personally those who are *her* patients. She barely has time to give the minimum of care from one room to another. This pressure, this haste, this detachment are henceforth part of her style. The patient, accustomed to seeing her seldom, accepts the fact as inevitable. He does not dare to bother the nurse with his worries, even though he is not sure his heart is still beating or that the injection he is being given is meant for him or for his neighbor. The nurse-patient relationship is becoming a non-relationship. Squeezed between the silent expectations of the anonymous patient and, on the other hand, the doctor-technicians whom she must understand and whose orders she must carry out, the nurse must often feel as though she is nothing more than a radar station in a system of telecommunications.

IV. Evolution and the new complexities of the nurse role are not phenomena peculiar to her profession. The material and institutional conditions under which professions are practised are all changing, at a faster or lesser tempo. Consequently, members of the various professions must occupy themselves, as often as necessary, with re-defining their patterns of behavior, taking into account both their ideal objectives and the unexpected demands of new circumstances. Association meetings, such as the present one, provide an opportunity for reconsidering the general goals and norms of a profession, with a view to bringing up to date the patterns of daily practice.

I have mentioned only the hospital

nurse, although I realize that an increasing number of nurses practise their profession in other institutions and in other places. Yet, that proportion is still not very high. At any rate the general standards of the profession are, and will remain for some time, determined by the characteristics of hospital practice. I feel sure that some of the dilemmas which I have mentioned apply in one way or another to all nurses.

It is not my role to suggest solutions. It is the concern of nurses themselves. It is their responsibility to decide, for example, whether they should improve the anonymity of the hospital or give back to their relationship with patients a certain degree of attention and human warmth. Even if the "average" patient whom I have mentioned is self-satisfied, hard to please and omniscient, he remains a vulnerable human being, one who needs people to be concerned about him. A recent study revealed that, in general, hospital patients were less concerned with what the nurse *did*, than with what she *was* to them. "What she is to them, and what she gives of herself, has the meaning and the value."[2] Likewise, it is the concern of nurses to overcome the dilemmas created by status conflicts with their colleagues, or the dilemmas which result, on the one hand, from the need to constantly improve their technical competence and, on the other, from time-consuming bureaucratic functions.

The nursing profession was born under the triple influence of religion, the army and science. From each of these it has inherited a prime virtue — charity, discipline, learning. In these three obligations, which serve also as models of behavior, it can still continue to find all the sources of imagination and audacity necessary to resolve its crucial dilemmas and conflicts.

References

1. Everett C. Hughes, Helen MacGill Hughes, Irwin Deutscher. *Twenty Thousand Nurses Tell their Story*. Philadelphia, J. B. Lippincott Company, 1958, pp. 169-70.

2. Hughes, Hughes, Deutscher. *op. cit.* p. 155.

SAD BUT TRUE

The ever-increasing cost of every commodity, every form of service has finally forced the Journal Board to take action regarding the subscription rates to *The Canadian Nurse* and its sister publication, *L'Infirmière Canadienne*. Sad but true, for the first time since October, 1947 new rates will come into effect on **June 1, 1962.** Here they are:

Subscriptions in Canada

Six months $2.25, one year $4.00, two years $7.00.

Student nurses (personal subscriptions only). One year $3.00, three years $7.00.

United States and other foreign countries

One year $4.50, two years $8.00.

Joint subscription, *The Canadian Nurse* and *The American Journal of Nursing* or *Nursing Outlook* one year $10.00.

Any new subscriptions or renewals postmarked prior to June 1, 1962 will be honored at the old rates. Present subscriptions may be renewed up to two additional years. After that date, all subscriptions paid at the old rates will be pro-rated on the basis of the new costs, e.g. $3.00 would pay for 9 months, $5.00 for 17 months, for Canadian subscriptions, and proportionately shorter periods for foreign subscriptions.

None of these rates is applicable, of course, to the tens of thousands of our subscribers who are members of their provincial registered nurses' associations and whose subscriptions are included in their annual membership fees.

The price of single copies, both back and current issues, is now 50 cents.

We are always getting ready to live but never living. — EMERSON

A work of art is a corner of creation seen through a temperament. — EMILE ZOLA

The Extension Course in Nursing Unit Administration

A progress report.

KATHLEEN RUANE

A YEAR AGO an article appeared in *The Canadian Nurse* announcing that a new course for nurses was to be launched in September, 1961. It was to be called an Extension Course in Nursing Unit Administration and the objectives of the course were:

1. To improve patient care through the application of basic principles of administration to the management of a nursing unit.
2. To help the head nurse develop an understanding of the administrative function inherent in the head nurse's position.
3. To assist the head nurse to coordinate effectively the service of the nursing unit with the services of other departments through improved methods of organization and communication.

The method of conducting the course was to provide an initial seminar or intramural session of five days, followed by a home study period of approximately seven months and a final seminar of five days.

At that time, what success would attend the course and what the response of the nurses would be were questions to which only future events would reveal the answers. It is still much too early to assess the effectiveness of the home study method as a means of teaching unit administration to head nurses, but the response of the nurse in this first year of the program can be measured. By May 31, 1961, over 600 applications for enrolment had been received. The Joint Committee of the Canadian Nurses' Association and Canadian Hospital Association, which governs the affairs of the Extension Course in Nursing Unit Administration, had set a quota of 250 students for the first year. There appeared to be wisdom in limiting enrolment as a great deal of organizing and preparation was necessary in an undertaking of such scope and novelty. Furthermore, the first year was to be a period of testing, with revisions to be made on the basis of experience gained. However, in view of the enthusiasm shown and the large number of applications received, 326 students were enrolled. It was expected that there would be a number of withdrawals before the fees were paid and the students actually appeared at the intramural seminars. Happily, these expectations were not realized. All but two of the 326 students were present at the seminars.

Intramural Sessions

The work conference method was used to conduct the seminars, that is, provision was made for small groups to discuss case studies and solve problems relating to nursing service administration. To ensure that this method would be effective and to encourage individual participation, attendance in each group was limited to 50 students where possible. The program included such subjects as: qualities of leadership, communications in the nursing unit, the influence of social change on nursing and staffing problems. Speakers for these subjects were selected from university schools of nursing and business administration, from departments of nursing service and from industry. Several films were also shown to illustrate the topics under discussion.

The nurses who enrolled were mature women, representative of the various levels of positions in nursing ranging from assistant head nurse to director of nursing. They were sincere and hard-working, and expressed a feeling of appreciation for the opportunity to attend a program that dealt with current problems in nursing service.

Six work conferences were held during September in the following centres: Vancouver, Edmonton, Winnipeg, London, Toronto and Halifax. Arrangements for accommodation and

equipment for the sessions were made with the assistance and cooperation of the nurses' associations in the respective provinces.

The final intramural sessions will be held in May, 1962 in the same centres as those conducted last September. The program will include such subjects as: human relations in administration, work simplification and budgeting for staff in the nursing unit. Provision will also be made for discussion of case studies in nursing service administration. An examination will be held at this session and a statement of achievement will be given if the student is successful and has completed all the home study assignments.

Extramural Sessions

Using the course objectives as guides, an outline of course content was prepared from which lesson plans were developed. These were sent to lesson authors to assist them in judging the scope of the material to be covered in each lesson. The authors were selected from members of the faculty of university schools of nursing, directors of nursing service and hospital administrators. When completed, the lessons were subjected to critical review by a committee of nurses experienced in the field of nursing service. In the light of recommendations made by this committee, the lessons were revised and made ready for printing. There is a total of twelve lessons.

That the nurses have carried over their interest into the home study period is evidenced by the fact that at the time of writing, only three have withdrawn from the course. This is also apparent when one considers that from 12 to 14 hours of study are required for the completion of each assignment which are sent out at 2-week intervals.

A lesson marker or tutor, is assigned to a student for the whole extramural session. By this means it is considered that a more valid evaluation of the student's progress can be made. To support the policy that each tutor was to have no more than five or six students, it was necessary to enlist the assistance of a large corps of qualified nurses engaged in nursing service administration. At the present time 55 of these nurses are involved in evaluating student assignments.

Conclusion

During this first year, there has been a great deal of interest displayed by the nurses in Canada in the Extension Course in Nursing Unit Administration. This was reflected not only in the large number who wished to enrol but also in the willingness of those who assisted in the preparation of lessons and those who agreed to act as tutors. The cooperation and support of the provincial nurses' associations were also given in the matter of securing the accommodation and equipment for the work conferences. It is too early yet to predict what influence the course will have on the performance of the nurses, but it was obvious that those attending the workshops were dedicated women who were grateful for the opportunity to discuss their problems and to receive direction in finding probable solutions.

The entire course will be repeated next autumn. For information regarding enrolment, see the advertisement on page 274.

ACCOMMODATION

1962 C.N.A. CONVENTION IN VANCOUVER

Name and Address	Comments	Revised Rates of Accommodation Single	Twin	Double	Twin Double	Suites
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HOTEL DEVONSHIRE 849 W. Georgia St.	Connecting doubles also available.	7.50 to 9.00	11.50 to 13.50	10.50 to 12.00	$15.00 up (triple)	20.50 to 22.00
*HOTEL GROSVENOR 840 Howe St.		6.50 to 7.00	10.00 to 11.00	9.00 to 9.50		
*HOTEL ALCAZAR Dunsmuir at Homer St.	1 block from Queen Elizabeth Theatre	5.00 to 6.00	7.00 to 9.00	5.50 to 8.00		
*ABBOTSFORD HOTEL 921 Pender St.	Cots at $1.50 $10.00 deposit by June 14.	6.50 up	8.50 up	8.00 up		
CASTLE HOTEL 750 Granville St.	One night deposit by June 10.	6.00 to 8.00	8.00 to 11.00	7.00 to 9.00		
GEORGIAN TOWERS MOTOR HOTEL 1450 W. Georgia St.	$3.00 per person over 2 per suite. Suites only.	11.00 up	13.00 up			17.00 up (2 bedroom)
BURRARD MOTEL 1100 Burrard St.	Downtown. Deposit by May 15.	7.00 to 10.00	11.00 to 13.00	9.00 to 13.00		20.00
DORIC HOWE MOTOR HOTEL 1060 Howe St.	Downtown. Cots $2.00. Heated swimming pool.	8.50 to 9.50	13.00	10.00	13.00 to 16.00	17.50 to 25.50
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FRASER ARMS HOTEL 1450 S.W. Marine Dr.	10 min. drive to Queen E. Theatre.	5.50	7.50		10.50 (triple)	
SKYLINE HOTEL 303, No. 3 Road Richmond	20 min. drive to Queen E. Theatre over toll bridge.	8.50	10.50 to 11.50			

NOTE: All rooms listed equipped with bath.
Rooms without bath available at lower rate at hotels marked*.
Deposit required at all motels.

Other attractive motels available in West and North Vancouver across Lion's Gate Bridge, a toll bridge where traffic is heavy morning and evening.

We would, however, be pleased to make reservations at your request.

ADJUSTING TO AMPUTATION

KAY MILLS

The loss of a limb can produce severe emotional stress.

FIRST IMPRESSIONS of Mrs. Jonah, an amputee following acute thrombophlebitis, were that she was a very obese, unhappy, childish woman. Although she was only average height — around 5′ 4″ — she weighed almost 300 pounds. She spoke only when absolutely necessary and then in a childish, uncertain voice. She seemed very sad, withdrawn and extremely nervous. Although she had just been dealt a serious blow with the amputation of her leg, her depression seemed beyond all reason.

Medical History

Shortly after the Christmas season Mrs. Jonah noticed swelling in her right leg at the knee.. This was accompanied by pain. At first she attributed it to her excess weight and her extra activity over the holidays. When the pain became more intense and home remedies failed to relieve it, she consulted her physician. Under his advice she went to bed for a period of two weeks during which time she received injections of penicillin to combat any infection present. The swelling and pain disappeared. After this period of inactivity, much to Mrs. Jonah's relief, she was able to get out of bed and resume her former activities in moderation. However, a day or two later the swelling returned. Much alarmed, Mrs. Jonah again consulted her doctor who recommended hospital care.

Mrs. Jonah was married to a hard-working, prosperous man. They lived in a modern house in a pleasant location where she had all the equipment to make housekeeping enjoyable. Although they were very fond of children, the Jonahs were childless and, in this respect, Mrs. Jonah appeared to feel that she had failed her husband.

Mrs. Jonah was very conscious of being overweight. She had placed herself on strict, low calorie diets many times, but usually these efforts were short-lived. She seldom lost more than a few pounds which she soon regained. Two of her brothers were also obese. She had had a thyroidectomy some years previously, with an excellent recovery.

In the interval between Mrs. Jonah's admission and the beginning of this study, which was three days after am-

putation, her right leg became increasingly swollen, cyanosed and numb, despite anticoagulant therapy. She suffered a great deal of pain. Gangrene was apparent. When therapeutic measures, such as compresses and the electric baker failed to bring about a return to normal, amputation was deemed essential. By this time Mrs. Jonah was suffering so much that she was willing to submit to anything that would bring relief.

Two weeks after admission Mrs. Jonah had her right leg amputated below the knee. Examination of the amputated limb by the pathologist revealed that she had been suffering from massive venous occlusion of the leg.

Nursing Care

Much of the nursing care was concerned with helping Mrs. Jonah to overcome her depression and accept the fact that her leg had been amputated. She was very particular about personal neatness and the tidiness of her surroundings. These were important to her morale. She was extremely modest and appreciated respect for her privacy. She had to be helped to realize that, although she had had a "tough break," things could certainly have been much worse. When her left leg began to show symptoms of thrombophlebitis she was understandably apprehensive and continually sought reassurance that it was only tired from carrying a double load. She was very anxious to go home, but was doubtful of her ability to do her own housework.

When left alone and allowed to concentrate on herself, she became very depressed. Many times she was found staring into space with tears rolling down her cheeks. Her mind had to be kept occupied with other things in order to prevent this. She needed encouragement, and seemed to benefit from it. One single word covered the nursing care plan for Mrs. Jonah — *understanding.*

Postoperatively, she experienced inability to void voluntarily, nausea and vomiting. Absolute privacy and simple nursing measures helped to overcome the problem of voiding. Despite laxatives and enemas it was not until she was able to go to the bathroom with assistance that she had a normal movement.

Nausea and vomiting presented a more serious problem. For many days after operation even the sight of food seemed to upset her. The tranquilizer, Largactil, finally gave her relief.

After bringing these problems under control, helping Mrs. Jonah to accept the loss of her leg became the chief concern. Whenever her dressing was changed she hid her face. She seemed almost ashamed of the stump and was careful to keep it hidden under the sheets. A matter-of-fact approach and frank discussion of the amputation helped her to overcome her fear or shame. Her advice was asked as to whether the bandage was high enough or tight enough. This made it necessary for her to look at the stump or at least acknowledge its presence. Soon she was able to look at it without cringing.

Under doctor's orders, Mrs. Jonah began to exercise both of her legs. She did so untiringly and uncomplainingly. She was quite surprised and pleased to see how well she could move her right knee joint. After investigating the use of a prosthesis she began to realize how fortunate she was to have so much of her leg remaining since a prosthesis could be fitted much better and could be manipulated with greater ease.

Mrs. Jonah appeared anxious to hear about people who had had similar amputations and were now living normal lives. One of the staff told her about patients whom he had worked with and helped. When Mrs. Jonah realized that she was only one of many who had the same disability her depression lessened to a certain degree.

A Complication

The day she got out of bed and into a wheelchair was a big event for Mrs. Jonah. At first she seemed very pleased but when she realized how helpless she was, she again became depressed. An attempt was made to interest her in reading, but before long she would begin staring into space, and it wasn't too difficult to guess where her thoughts were wandering. She did not visit with other patients, or even chat with the nurses. She seemed too "wrapped up in herself" to care about

anything else. One day one of her friends brought in some embroidery work for her. Having her hands busy seemed to help her to overcome her depression. She was just beginning to return to normal and to talk of returning home when complications occurred.

Mrs. Jonah's left leg became slightly swollen, tender and reddened. This was accompanied by pain and slight cyanosis of the foot. The doctor placed her on complete bed rest once more. This was quite a blow. She became withdrawn and refused to be cheered up. She convinced herself that the discomfort was in no way connected with the condition that had necessitated the removal of her other leg. With the application of tensor bandages to her leg from instep to thigh, the swelling decreased. After it had completely disappeared, she was again allowed up in the wheelchair with tensor bandages. Soon she was wheeling herself up and down the corridor.

Crutch Walking

The next step toward recovery was learning to walk on crutches. Mrs. Jonah was eager to try them. She found them awkward at first but she persisted in practising. It was evident to her that she was progressing rapidly and would soon return home. Her mental outlook improved as well.

Patient Teaching

Before her discharge she was taught how to apply the tensor bandage to her left leg and her right stump. The purchasing and fitting of artificial limbs was discussed with her and she was told where she could obtain more information. She was cautioned to report any painful or swollen areas to the doctor immediately. Her husband had previously purchased a wheelchair and hired a maid to smooth the way for Mrs. Jonah's discharge. She was very excited and nervous about going home, but, reassured by the provisions made for her return, she soon became calm. Our last glimpse of her was when she was sitting comfortably and happily beside her husband in their car.

We are taught to treat each patient as an individual but first we must come to know the person. What kind of a person is she? What is her problem? Is she able to face that problem and cope with it? How can she be helped? All this can be learned only with much tact, practice and patience.

God offers to every mind the choice between truth and repose. — EMERSON

New Publications

Mathematics of Drugs and Solutions by Dorothy Walton Parry, B.A., M.A. 142 pages. G. P. Putnam's Sons, New York. 3rd ed. 1961.

An exercise book for the nursing student to use in reviewing the mathematical principles applicable to the administration of medications.

Personal and Vocational Relationships for Practical Nurses. Christine H. Bush, R.N. 107 pages. W. B. Saunders Company, 3207 Washington Square, Philadelphia. 1961. Price $1.50.

The author's purpose was to assemble material on professional adjustments for auxiliary nursing personnel into textbook form. In her experience most texts on this subject were prepared for professional nurses with little reference to the specific problems of practical nurses.

There is discussion of effective study methods; group organization and parliamentary procedure; the various practical nurse organizations to be found in the U.S. and their functions; personal etiquette; nursing ethics; job opportunities and a variety of other topics affecting nurse-patient and nurse-personnel relationships.

Nursing Home Standards Guide. U.S. Department of Health, Education and Welfare, Division of Chronic Diseases, Washington 25, D.C. 1961. Price 45 cents.

The booklet contains "recommendations relating to standards for establishing, maintaining and operating nursing homes." The aim of the material is to assist state and local licensure agencies or other regulatory groups in all matters related to the establishment, maintenance and operation of nursing homes. The information presented has value for Canadian readers in that there is much general discussion of the various services required for nursing homes; desirable physical facilities; factors in safety, maintenance, operation and administration.

Psychiatric Nursing. A Basic Manual. By Annie Laurie Crawford, R.N., B.S., M.Ed. and Barbara Boring Buchanan, R.N., B.S., M.S. 88 pages. The Ryerson Press, 299 Queen St. West, Toronto 2B. 1961. Price $2.50.

This is a simplified presentation of principles in the nursing care of the mentally ill. It is designed for use in teaching professional nurses, auxiliary nurses, psychiatric aides and attendants. A chapter related to mental health and the nurse emphasizes the necessity for the nurse to understand herself and to know how to meet her own needs. The care of the anxious, withdrawn, suspicious, depressed, excited or aged patient is outlined. Special needs of patients with organic or toxic conditions are considered separately.

A Niche of Usefulness. Department of Labor of Canada. 53 pages. Queen's Printer and Controller of Stationery, Ottawa. 1961. Price 25 cents.

"This pamphlet traces the growth of vocational rehabilitation services in Canada and documents women's participation in various phases of existing programmes. It tells how the services are organized and how the individual may make use of them."

This booklet presents extremely useful material for those working with handicapped persons or for private individuals who require specific information about rehabilitation services.

The Use and Training of Auxiliary Personnel in Medicine, Nursing, Midwifery and Sanitation. World Health Organization Technical Report, Series No. 212. 26 pages. WHO, Palais des Nations, Geneva. 1961. Price 30 cents.

This report was prepared by experts in the field of professional and technical preparation of medical and auxiliary personnel.

Four types of auxiliary personnel are considered — medical assistants, auxiliary nurses, auxiliary midwives and auxiliary sanitarians. Selection of candidates, their functions, their training and their supervision are discussed. There is also a section on the orientation of professional groups in the use of auxiliary personnel and another on the increasing need for such workers.

Experimental Chemistry for Student Nurses by Grace Keller Jones, M.A. 115 pages. McAinsh and Company Limited, 1251 Yonge Street, Toronto.

This is a laboratory manual for the student nurse studying chemistry. The experiments outlined are designed to demonstrate and explain many chemical processes in the body.

Central Sterile Supply. Edited by Brian Watkin, S.R.N., B.Sc. 58 pages. A *Nursing Times* publication, Macmillan & Co. Ltd., St. Martin's Street, London, WC2. 1961.

The booklet contains a general discussion of central supply departments and describes the units in several hospitals in England.

EMPLOYMENT OPPORTUNITIES

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THE CANADIAN NURSE JOURNAL
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Head Nurse with postgraduate preparations in pediatrics, or preparation & experience as head nurse, for 30-bed Pediatric Department. Salary $315 - $355, good personnel policies. Apply: Director of Nursing, St. Michael's General Hospital, Lethbridge, Alberta.

Registered Nurses for modern 70-bed General Hospital, salary $295-$320 per mo., 40-hr. wk., liberal policies, yearly increments, residence available. Situated in beautiful Peace River Country, French & English population. Apply: Sister Superior, Sacred Heart Hospital, McLennan, Alberta.

General Duty Registered Nurses for 44-bed active treatment hospital. Salary $325 per mo. with bi-yearly increments of $5.00 each, 40-hr. wk., R & B $40 per mo. in new residence, attractive holiday & sick leave benefits, medical & hospitalization coverage. Apply: P.O. Box 339, Spirit River, Alberta.

General Duty Nurses — starting salary $290 per mo., 40-hr. wk., board, room & laundry available, if desired, $30 per mo. Civil Service holiday, sick leave & pension programs. Apply to: Baker Memorial Sanatorium, Calgary, Alberta.

General Duty Nurses (2) Salary $295-$325 per mo. Starting salary to nurse with 1 year experience $305, plus other benefits, 40-hr. wk. Train fare from any point in Canada will be refunded after one year's employment. For full particulars apply to: Municipal Hospital, Two Hills, Alberta, PHONE 335.

General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton, $285-$335 gross salary for Alberta registered, $275-$325 gross salary for non-registered in Alberta. Excellent personnel policies & working conditions. Apply to: Matron, Municipal Hospital, Brooks, Alberta.

BRITISH COLUMBIA

Director of Nursing for 40-bed hospital at Merritt, B.C. Construction of new hospital will commence August 1962. Please apply by letter giving full details of training, experience, qualifications & salary required, to: Administrator, Nicola Valley General Hospital, P.O. Box 129, Merritt, British Columbia.

Director of Nurses for modern, active 17-bed hospital to commence duty June 1st. Salary $375 to $425 dependent upon experience. RNABC policies in effect. Full board in own suite provided for $40 per mo. Applicant must have or be eligible for B.C. Registration. For further details write to: Mrs. M. Penn, Director of Nurses, General Hospital, Tofino, British Columbia.

Nursing Supervisor B.C. Registered for new hospital at Golden, British Columbia, picturesque village in the beautiful Canadian Rockies, on C.P.R. & Trans-Canada Highway, 170-miles west of Calgary, Alberta. Please indicate qualifications & salary expected. Full information regarding duties & hospital operation & organization available on request. Apply to: C. F. Collins, Administrator, Golden & District General Hospital, P.O. Box 230, Golden, British Columbia.

Registered Nurse for 45-bed hospital, salary range $299 - $359 per mo., 8-hr. duty, 40-hr. wk., board & room $50 per mo., 28-day annual vacation, 10 statutory holidays, 1½ days sick leave per mo., sick leave accumulative to 120 days, good climate, pleasant surroundings, friendly community. Reply at once to the: Director of Nursing, Fernie Memorial Hospital, Fernie, British Columbia.

General Duty Nurses for small active hospital. Salary $282 for unregistered Nurses in B.C. $297 registered with yearly increments. Nurses' home available. For further particulars write: The Administrator, Lady Minto Hospital, Ashcroft, British Columbia.

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary range $297 to $359. Pre-planned shift rotation, B.C. registration essential, 4-wk vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for new 82-bed hospital in the Aluminum City of Northern B.C. Salary RNABC recommendation plus $15 per mo., 40-hr. wk., 9 statutory holidays, 1½ days sick leave per month accumulative to 60 days. Residence with board $50 per mo., superannuation & 50% medical care plan paid. Increments for experience & postgraduate certificate. Apply to: Director of Nursing, General Hospital, Kitimat, British Columbia.

General Duty Nurses for 123-bed General Hospital on Vancouver Island. Personnel policies in accordance with RNABC. For further information write to: Director of Nursing, General Hospital, Nanaimo, British Columbia.

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary—non-registered $297, B.C. registered $312-$374. Travel allowance, newly furnished residence available. For full details contact: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurses for well-equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathlyn & Hudson Bay Gacier. Initial salary $312, maintenance $47.50, 40-hr. 5 day wk., 4-wk. vacation. Boating, fishing, swimming, golfing, curling, skating, skiing. Comfortable nurses' residence, rail fare advanced if necessary. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses starting salary $311 if 2 years experience, $297 to $359 in four years, non-registered $282. Maintenance $50. 10 statutory holidays, 4-wk. annual vacation, 1½ days sick leave monthly. Very active town, world famous Cariboo Cattle country, annual stampede. Marriages reason for vacancies. New hospital opening in 1962. Apply: Director of Nurses, War Memorial Hospital, Williams Lake, British Columbia.

General Duty Nurses, Operating Room Nurses (with postgraduate or equivalent) in very active 146-bed General Hospital. Personnel policies in accordance with RNABC. Rooms available in nurses' residence. Apply: Director of Nursing, General Hospital, Chilliwack, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $297-$359. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Salary for B.C. Reg'd. Nurses $297 with regular increases; Unreg'd., $285. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 year. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

Graduates Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $297 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

Graduate Nurses for 20-bed hospital, 35-mi. from Vancouver, on Coast. Salary & personnel practices in accord with RNABC. Bus & train transportation, accommodation available. Apply: Director of Nursing, General Hospital, Squamish, British Columbia.

Graduate Nurses (2) for General Duty in small hospital, salary $297 per mo., 10 paid statutory holidays, 28-day vacation after 1-yr. service, room, board & laundry $40 per mo., superannuation & sick leave benefits. Apply, giving full particulars, to: Administrator, Slocan Community Hospital, New Denver, British Columbia.

Nurses (2) for 30-bed hospital. Salaries as per B.C. Registered Nurses' agreement. Comfortable nurses' home. Apply to: Miss H. Campbell, R.N., Director of Nursing, Community Hospital, Grand Forks, British Columbia.

Nurses (2) for United Church Mission Hospital in northern B.C. Salary: $305 per mo. also **Trained Practical Nurses** (2) salary $210 per mo. An opportunity for Christian service. Apply: Wrinch Memorial Hospital, **Hazelton, British Columbia** or Dr. M. C. Macdonald, Board of Home Missions, United Church, 85 St. Clair Ave. East, **Toronto, Ontario.**

STOP! Would you like to work in a small 50-bed active, friendly hospital? Permanent & holiday relief nurses required at Langley Memorial Hospital, 35-mi. from Vancouver. Apply to: Director of Nursing, Langley Memorial Hospital, Murrayville, British Columbia.

MANITOBA

Registered Nurse for 12-bed hospital in Lynn Lake, Manitoba. Salary $325 per mo. plus room & board. Group insurance, medical & hospital, pension plan available, 44-hr. wk., liberal holiday schedule. For further particulars apply to: W. F. Clarke, Personnel Manager, Sherritt Gordon Mines Limited, Lynn Lake, Manitoba.

General Duty Nurses (3) for new 85-bed hospital. Good salary & generous personnel policies. Apply: Director of Nursing, Portage Hospital District #18, Portage La Prairie, Manitoba.

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Clinical Instructor with postgraduate course for operating room, basic salary $325, also **Registered Nurses** as scrub nurses for operating room, basic salary $260, experience & course considered. 226-bed hospital, good personnel policies. Bilingual population. Positions available immediately. Apply: Director of Nursing, Hotel-Dieu Hospital, Edmundston, New Brunswick.

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General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses for modern 21-bed General Hospital on scenic Eastern Shore. Nova Scotia salary scale, 3-wk. annual vacation, sick leave, pension plan & 8 statutory holidays, good personnel policies, residence accommodations. Apply, giving name of training school, date of graduation & record of employment & experience to: Superintendent, Eastern Shore Memorial Hospital, Sheet Harbour, Nova Scotia.

ONTARIO

Director of Nursing for 75-bed hospital completed in 1956 with addition completed in 1961. Present Director resigning because of ill health. Please enclose references, give full particulars & date available in letter to the: Secretary, Dryden District General Hospital, Dryden, Ontario.

Director of Nurses for Ongwanada Sanatorium, Kingston, Ontario. Apply to: The Medical Director, 790 Princess Street, Kingston, Ontario.

Assistant Director of Nursing Service, with postgraduate preparation. Good salary & personnel policies. Apply to: Director of Nursing, St. Joseph's Hospital, Chatham, Ontario.

Assistant Superintendent of Nursing for modern 52-bed hospital. Salary commensurate with experience & qualifications. Residence accommodation available, operating room experience essential. Apply to: Superintendent, General Hospital, Kincardine, Ontario.

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Obstetrical Clinical Instructor, good personnel policies. Apply: Director of Nursing, Belleville General Hospital, Belleville, Ontario.

Head Nurse, Case Room, for progressive obstetrical department in new construction. Previous supervisory experience essential. Day hours of duty; salary in accordance with qualifications. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical, Operating Room & Obstetrical services, at Ajax, Ontario on Highway 401, 20 mi. east of Toronto, hourly bus service to hospital. Salary in accordance with qualifications & experience, increments every 6 mo., sick & vacation time after 6 mo., sick time cumulative to 14 days, 37½-hr. work wk., pension plan, living-in accommodation. Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom,** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

Registered Nurses for 100-bed General Hospital. Salary range $320 - $360 per mo., 3-wk. vacation, paid sick leave, pension plan in effect, accommodation in nurses' residence if desired, room & board $45 per mo. For particulars apply: Director of Nurses, Lady Minto Hospital, Cochrane, Ontario.

Registered Nurses for 34-bed hospital, min. salary $320, 3-wk. vacation with pay, sick leave after 6-mo. service. **Certified Nurses Assistants** salary $220, 2-wk. vacation with pay. **All staff** — 5-day 40-hr. wk., 9 statutory holidays, pension plan & other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario.

Registered Nurses eligible for Ontario registration, for General Duty in 29-bed hospital near Timmins. Gross salary $320 per mo. with annual increments to $360. 40-hr. wk., usual fringe benefits. Living accommodation in nurses' residence at $45 per mo. Apply to: Superintendent, Bingham Memorial Hospital, Matheson, Ontario.

Registered Nurses & Certified Nursing Assistants for modern 75-bed hospital. Starting salaries — R.N.'S $310 per mo., C.N.A.'S $220 per mo. Single room accommodation available in the residence. Dryden (population 6,500) an industrial town, also center of extreme tourist area, is conveniently located midway between Winnipeg & the Canadian Lakehead. For further information regarding personnel policies, community activities, etc. please call or write: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario.

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Registered Nurses & Certified Nursing Assistants for 160-bed accredited hospital. Starting salary $320 & $220 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Hospital of Ontario pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario.

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Registered Nurses for General Duty in all departments including premature & new-born nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80,000 people. **Salary: $305 per mo.** with annual merit increments, plus **annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for General Duty in modern 18-bed Private Hospital in iron mining town, 140 mi. north of Sault Ste. Marie, Ontario. Starting salary $290 min. to $330 max. for experience, less $20 per mo. for maintenance. Excellent accommodations & personnel policies, transportation allowance after 6-mo. service. **Operating Room Nurse** starting salary $310 min. with postgraduate course. $350 max. with 3-yr. experience or more. Apply: Superintendent of Nurses, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for Geneeral Duty Staff for 106-bed General Hospital. Salary $295 plus $5.00 raises after 6-mo., 1 year, 1½ years, 2 years, 3 years & $10 after 5th year to maximum of $330 per mo. Evening differential $10 per mo. with night differential $5.00 per mo. Apply to: Director of Nursing, Norfolk General Hospital, Simcoe, Ontario.

Registered General Duty Nurses (Immediately) for all departments in new 259-bed hospital located in Niagara Peninsula. Starting salary $305 with 3 annual increments to $335 per mo., 5-day 40-hr. wk. with 3-wk. annual vacation, pension plan, etc. Residence accommodation available. Apply to: Director of Nursing, County General Hospital, Welland, Ontario.

Registered Staff Nurses for case room & operating room for 325-bed General Hospital located in central area of city. Rotating hours of duty; attractive personnel policies. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. All patients' services in new modern building opened in November 1960. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

General Duty Nurses for an accredited 66-bed hospital. Starting salary: $305. Excellent personnel policies, pension plan, residence accommodation only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for modern 100-bed hospital. Registered start at $300 monthly, Graduates $250 - $285; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. **Male Nurse,** graduate or registered also needed. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $285 per mo. with recognition for P.G. courses, 40-hr. wk. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

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A certificate in Administration and Supervision in public health nursing.

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This is a permanent appointment with excellent employee benefits. The present staff establishment is as follows:

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1 — Assistant Director
3 — District Supervisors of Public Health Nurses
40 — Public Health Nurses

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1st year	2nd year	3rd year	4th year	5th year
$5,500	$5,750	$6,000	$6,250	$6,500

(Starting salary dependent upon qualifications and experience)

Apply by letter giving full details as to age, qualifications and experience to the
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Public Health Nurses (qualified) Salary $3,700 to $4,700, annual increment $200, car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Box 337, Cobourg, Ontario.

Public Health Nurses required by Stormont, Dundas & Glengarry Health Unit for generalized program in Seaway Development Area, usual benefits, liberal car allowance, pension plan, allowance for experience. Apply to: Dr. Paul S. deGrosbois, Medical Officer of Health, Health Unit, 26 Pitt Street, Cornwall, Ontario.

Public Health Nurses (Qualified). Salary $3,900 - $4,875, annual increment $195. Transportation provided, the usual employee benefits. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, Oshawa, Ontario.

Public Health Nurses—Minimum salary $3,800, allowance for experience up to the maximum of $4,750. Car allowance, pension plan, & other benefits. Personnel policies on request. Apply to: Dr. J. M. McGarry, M.O.H., St. Catharines-Lincoln Health Unit, St. Catharines, Ontario.

Public Health Nurses for generalized program, salary range $3,700 - $4,500 (minimum based on experience). Good personnel policies, 3-wk. vacation, accumulative sick leave, pension plan & other benefits. Apply to: Dr. J. Howie, Director, Metropolitan Windsor Health Unit, 2090 Wyandotte Street East, Windsor, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose & throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Operating Room Supervisor for modern, accredited 55-bed hospital. 40-hr. wk., 1-mo. vacation. Living accommodation available in new motel-style nurses' residence. Apply stating qualifications to: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Nursing Instructor (Psychiatric) for large affiliate, **Postgraduate & Nursing Assistant program.** Apply giving full particulars of training & employment record to: The Director of Nursing, Verdun Protestant Hospital, 6875 La Salle Blvd., Verdun, Quebec.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for 30-bed General Hospital, 50 mi. from centre of Montreal, excellent bus service. Starting salary $275 per mo., 3 semi-annual increases, 40-hr. wk. 4-wk. annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

Registered Nurses & Certified Nursing Assistants for modern 55-bed General Hospital, salary $300 per mo., 5 semi-annual increases, 40-hr. wk., 4-wk. vacation. **Certified N.A.** starting salary $210, 3-wk. vacation, accommodation available in new motel-style residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Registered Nurse for Private Hospital in Pointe Claire, Que. Salary $300 per mo., sleep in, private room, board. Apply: 27 Lake Shore Road, Pointe Claire, Quebec. Phone No. OXford 5-9384.

SASKATCHEWAN

Obstetric Supervisor responsible for supervision of 25-bed unit, & clinical instruction of students. Also **Nursing Arts Instructor, & Medical-Surgical Clinical Instructor,** new 185-bed General Hospital opening March, 1962. School of Nursing — 61 students. Apply: Director of Nursing, Yorkton Union Hospital, Yorkton, Saskatchewan.

Registered Nurses (2 immediately) for Union Hospital, Mossbank, with Dr. J. E. Miller in attendance. Salaries as per SRNA with increments & benefits. 40-hr. wk., fully modern nurses' residence, daily bus service to the city, recreational opportunities. Apply to: Fred Howlett, Hospital Sec., Mossbank, Saskatchewan.

U.S.A.

Staff Nurse for 29-bed mission hospital in frontier type town under the auspices Women's Division Methodist Church. Excellent personnel policies. Contact: Administrator, Maynard-McDougall Memorial Hospital, Nome, Alaska.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $360 with range to $420 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses (Come to sunny California) **Staff Nurses for permanent positions,** various departments, days, eves., nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $345 - $415, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $350 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered Nurses & Licensed Practical Nurses for hospital with new wing to open in May. Total capacity of 365-beds. Need nurses for medical-surgical, obstetrics, recovery room & emergency room. Starting salary for days: $355 per mo. with $25 differential for evenings & nights. Regular raises. Practical Nurses starting salary is $260 per mo. Good personnel policies. For further information write to: Director of Nursing Service, St. Mary's Hospital, 509 E. 10th. Street, Long Beach, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $4,320 to $5,400 per year. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Staff Duty positions in private 428-bed hospital, non-registered graduates acceptable. Liberal personnel policies & salary. Write to: Personnel Director, Hospital of the Good Samaritan, 1212 Shatto Street, Los Angeles 17, California.

Office Nurses (eligible for California registration) for group of 20 private practice Specialists near Los Angeles, Starting salary $360 per mo. Contact: J. A. Woodruff, 10720 Paramount Blvd., Downey, California.

Graduate Nurses (Professional) We are an established teaching hospital offering a variety of interesting assignments in patient-centered care. The current starting salary for Staff Nurse is $390 per mo., for evenings $430 & nights $420 per mo., for a 40-hr. 5-day wk. Fringe benefits include paid vacation up to 4 wks. per yr., 8 paid holidays per year, cumulative sick leave, Blue Cross & pension plan available. The hospital is centrally located & offers private room accommodations in our modern nurses' residence. Your inquiries are invited: Director of Nursing Service, Department C.J.N., Mount Sinai Hospital of Chicago, 2750 West 15th Place, Chicago 8, Illinois.

Staff Nurses & Licensed Practical Nurses (Openings in several areas, all shifts.) 37½-hr. work wk., in small community hospital, 2-mi. from Boston. Living quarters available. Minimum starting pay $73 R.N.'s; L.P.N.'s $61 per wk. Experience considered, differentials for reliefs, nights. Contact: Miss Elizabeth Hewitt, Assistant Director of Nurses, Chelsea Memorial Hospital, Chelsea, Massachusetts.

Professional Nurses of High Calibre for 800-bed General Hospital: Metropolitan area. All specialties, convenient to universities, liberal personnel policies. 7-3 tour $4,100 - $5,000 — 3-11 tour $4,460 - $5,360 — 11-7 tour $4,340 - $5,240. For further information write: Mrs. Alice O. Schoonmaker, R.N., M.A., Director of Nursing, Martland Medical Center, 65 Bergen Street, Newark 7, New Jersey.

Staff Nurses 380 bed hosp. new 120 med-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds. & O.R., salaries $315 per mo. even., night or O.R. with call; 6-mo. increases up to $375; days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent P.M. of night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. — 2 wks., 2 yrs. — 3 wks. 5 yrs. — 4 wks. Active inservice pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611.

Courses FOR R.N.'S N.Y. POLYCLINIC MED. SCH. & HOSP. — in heart of Manhattan — 6-mo. courses in: O.R. NURSING OPD. NURSING, MED.-SURG. NURSING. Classes 4 times yrly: Mar., June, Sept., Dec. Room, meals, Medical Care & monthly cash stipend. Positions available to graduates of our Courses. For information write: Director of Nursing Education, 345 W. 50 St., N.Y.C., NEW YORK.

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Staff Nurses: Exchange Visitor program offers opportunities to learn & earn at large modern tuberculosis hospital in convenient suburban Cleveland, Ohio. Start at $344 per mo. with semi-annual increments. 5-day work wk., paid vacation & 6 holidays, liberal sick leave, board, room & laundry at low rate in pleasant accommodations in nurses' home. Increase your professional experience at a progressive accredited hospital in an expanding community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

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Staff Nurses for 750-bed General Hospital. Liberal personnel policies, 40-hr. wk., opportunities for continuing education. Write to the: Department of Nursing, Hospital of the University of Pennsylvania, 3600 Spruce Street, Philadelphia 4, Pennsylvania.

Staff Nurses (All Clinical Services) Base salary $319, differential for 3-11 and 11-7 shifts, liberal personnel policies incude sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

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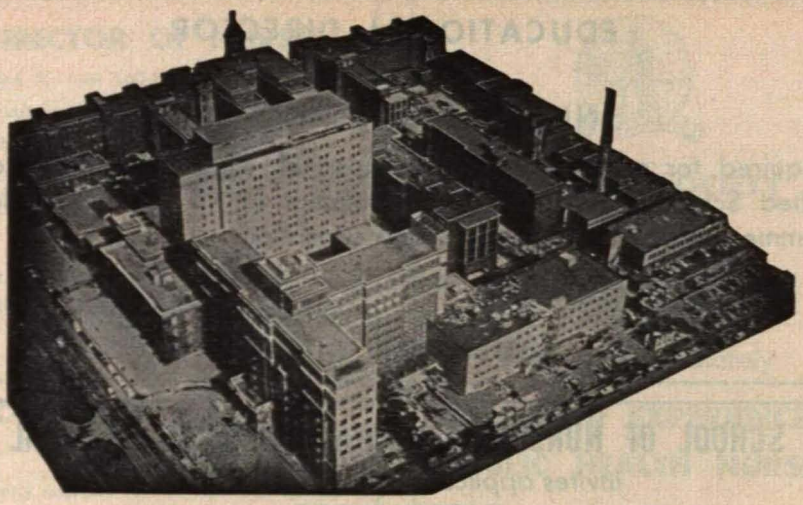
ONTARIO

Assistant Director of Nursing, Operating Room Supervisor for 100-bed hospital with expansion program. For further information write: Director of Nursing, Civic Hospital, North Bay, Ontario.

Head Nurse, Pediatric Department for 22-bed General & Marine Hospital, Owen Sound, Ontario. Good personnel policies & salary. **VACANCY: IMMEDIATELY.** Apply: Director of Nursing, General & Marine Hospital, Owen Sound, Ontario.



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Rewarding Experience — Excellent Personnel Policies

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Director of Nursing, Toronto General Hospital, 101 College Street, Toronto 2, Ontario

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GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary $320 monthly with annual increments for 3 years to $350.

Until registration in Ontario is established — $295.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days after one year.

Annual sick time 12 days after one year, cumulative to 18 days. Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

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EDUCATIONAL DIRECTOR
also
NURSING INSTRUCTOR

Required for a modern 150-bed hospital, which has long established School of Nursing with enrolment of 75 students. Salary commensurate with experience and education.

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SHERBROOKE, QUEBEC

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This school conducts a progressive program for about 50 students, in connection with an active hospital of over 200-beds. A new wing will be occupied very shortly. Salary commensurate with experience and qualifications.

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Salary $305 with annual increments, allowance for experience and postgraduate training, 40 hour week — 9 statutory holidays, 3 week vacation after one year — 4 weeks thereafter, 1 day sick leave per month accumulative, generous fringe benefits, nurses' residence—board $45 per month.

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On paved highway 38 miles from Winnipeg. New construction program well advanced.

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Bldg. completed Oct. 1961.

165-beds; full complement of services; good personnel policies.

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YARMOUTH HOSPITAL
YARMOUTH, NOVA SCOTIA

OTTAWA CIVIC HOSPITAL

requires

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for

OPERATING ROOM
MEDICAL
SURGICAL
OBSTETRICAL
& PSYCHIATRIC
} DEPARTMENTS

Apply

EDITH G. YOUNG, REG. N.,
ASSISTANT DIRECTOR AND
ADMINISTRATOR OF THE DEPARTMENT
OF NURSING.

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wanted for new 160-bed General Hospital opening approximately May 1, 1962. Must be able to take complete charge of nursing staff. Excellent salary and working conditions.

Write or phone:

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Overseas inquiries invited.

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urgently required for new 160-bed General Hospital opens May 1, 1962. Excellent salary and working conditions.

For further information write or phone:

DR. J. TEITELBAUM, 5757 DECELLES REgent 1-0772

Overseas inquiries invited.

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and

CERTIFIED NURSING ASSISTANTS

also

Registered Nurse

with operating room experience, required for 200-bed hospital situated in a beautiful residential town on the shores of Lake Temiskaming. Starting salaries $320 for R.N.'s and $220 for C.N.A.'s. Good personnel policies including 40 hour week, O.H.A. pension plan etc. Accommodation available in residence if desired.

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HAILEYBURY, ONTARIO

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CRIPPLED CHILDREN

Requires Immediately

QUALIFIED EXPERIENCED PUBLIC HEALTH NURSES

YOU WILL RECEIVE —

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- FREE INSURANCE
- 3-MONTH TRAINING COURSE

You will deal directly with children, their parents and service club members.

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ONTARIO SOCIETY
FOR CRIPPLED CHILDREN
350 RUMSEY ROAD
P.O. BOX 1700, STATION "R"
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REGISTERED NURSES
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Salaries in accordance with accepted practice in the locality as indicated below. A higher rate may be paid for recent acceptable experience. Specialty allowances will be paid for postgraduate training or education which is utilized in the performance of the duties of the position.

Victoria Veterans Hospital, Victoria, B.C. ($3,600)
Shaughnessy Hospital, Vancouver, B.C. ($3,600)
Colonel Belcher Hospital, Calgary, Alta. ($3,450)
Deer Lodge Hospital, Winnipeg, Man. ($3,450)
Westminster Hospital, London, Ont. ($3,450)
Sunnybrook Hospital, Toronto, Ont. ($3,450)
Queen Mary Veterans Hospital, Montreal, P.Q. ($3,300)
Ste. Anne Veterans Hospital, Ste. Anne de Bellevue, P.Q. ($3,300)
Lancaster Hospital, Lancaster, N.B. ($3,150)
Camp Hill Hospital, Halifax, N.S. ($3,000)

BENEFITS:

Pension plan; three week's paid vacation; three week's cumulative sick leave; five day week. Cotton uniform and laundering of same will be provided. In some centres low cost living in staff residences is also available.

Applications are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists:

VANCOUVER, 1110 Georgia St. W., EDMONTON, 107 St. & 99 Ave., WINNIPEG, 266 Graham Ave., TORONTO, 25 St. Clair Ave. E., MONTREAL, 1165 Bleury St., SAINT JOHN, Canterbury St., HALIFAX, 105 Hollis St.

CLINICAL INSTRUCTOR

in

PRINCIPLES AND APPLICATION OF OPERATING ROOM TECHNIQUE

Diploma in nursing education and experience in the operating room preferred.

This is a modern 300-bed hospital with plans now underway for expansion in 1962.

The school for nurses is well equipped and has a total enrolment of 94.

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WOODSTOCK, ONTARIO

requires

SURGICAL CLINICAL TEACHER

PREFERABLY WITH B.Sc.N. DEGREE AND EXPERIENCE. POSITION WILL BE OPEN ON AUGUST 1, 1962.

SALARY COMMENSURATE WITH QUALIFICATIONS AND EXPERIENCE.

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required for Mental Health Services, ESSONDALE, B.C.

Salary $313 - $373 per month. Applicants must be Canadian citizens or British subjects and be registered with the Registered Nurses' Association of B.C. Must have post-basic preparation in teaching and supervision; preparation in psychiatric nursing and satisfactory experience in general and/or psychiatric nursing. Duties include instructing students in the principles and practices of nursing; demonstrating accepted methods of nursing services and rendering individual assistance to promote patient safety; maintaining co-operative inter-departmental relationships. For further information and application forms apply IMMEDIATELY to The Personnel Officer, B.C. Civil Service Commission, ESSONDALE, B.C.

COMPETITION NO. 62:7 A.

GUELPH GENERAL HOSPITAL

ACTIVE — 200-BEDS — FULLY ACCREDITED

Requires

GENERAL STAFF NURSES

CERTIFIED NURSING ASSISTANTS

Pleasant city of 40,000

Close to larger centres

Excellent personnel policies

For further details apply to:

THE DIRECTOR OF NURSING
GENERAL HOSPITAL
GUELPH, ONTARIO

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PUBLIC HEALTH NURSES

for Staff and Supervisory positions in various parts of Canada.

Applications will be considered from Registered Nurses without Public Health training but with University entrance qualifications.

SALARY, STATUS AND PROMOTIONS ARE DETERMINED IN RELATION TO THE QUALIFICATIONS OF THE APPLICANT.

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ASSOCIATE DIRECTOR of NURSING SERVICE

434-bed General Hospital

with

School of Nursing

200 students

Good personnel policies.

Salary commensurate with preparation and experience.

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NEW WESTMINSTER, B.C.

SAINT JOHN GENERAL HOSPITAL,

Saint John, N.B.

requires a

SUPERVISOR

for

Pediatric Division

74-beds

A CLINICAL INSTRUCTOR

is responsible for

Student Program

For Information Apply To:

Director of Nursing

NURSING SUPERVISOR
and a
REGISTERED NURSE
for

110-bed "HOME FOR THE AGED" with 50-bed bed-care wing. Located on Grand River, Niagara Peninsula within 1 hour's travel to Hamilton, Niagara Falls and Buffalo, N.Y. Modern staff quarters optional.

FOR FULL PARTICULARS APPLY SUPERINTENDENT, STATING QUALIFICATIONS, EXPERIENCE AND REMUNERATION.

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ONTARIO SOCIETY FOR CRIPPLED CHILDREN,
BOX 1700, POSTAL STATION "R",
350 RUMSEY ROAD, TORONTO 17,
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AND
CERTIFIED NURSING ASSISTANTS
REQUIRED FOR

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for salary rates & personnel policies
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Please apply giving full particulars of training and experience to:

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MUNICIPAL HOSPITAL,
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HEALTH EDUCATION BURSARY REQUIREMENTS

1. Baccalaureate degree with preparation in public health education. Education courses may be supplemented at summer school prior to fall admissions. Must have high scholastic standing to meet the admission requirements of the University of Michigan or California.
2. At least 3 years professional experience.
3. Three letters of recommendation.
4. A personal interview is required at the O.T.A. office.
5. At least 2 years service with the O.T.A. following the course. Must be free to travel throughout the province and to locate in a specific region to develop the health education program.

AMOUNT

Bursary $4,500; Salary $4,800 minimum plus expenses.

APPLY

MISS FLORIS E. KING, B.Sc.N., M.P.H.
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ONTARIO TUBERCULOSIS ASSOCIATION
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Positions available immediately for Registered Nurses, general duty in new wing of hospital, intensive care unit, general medical and surgical wards and obstetrical unit. Salaries are paid in accordance with recommendations of Association of Nurses of the Province of Quebec and commensurate with experience and education.

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2100 MARLOWE AVE., MONTREAL 28, QUE.

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ASSISTANT DIRECTOR OF NURSING SERVICE

McKELLAR GENERAL HOSPITAL,
FORT WILLIAM, ONTARIO.

Position will be open on April 1, 1962. Salary commensurate with qualifications and experience.

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REGISTERED NURSE for Infirmary in School of 250 boys age 14 to 19. Living Quarters provided.

Apply to the Headmaster

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CANORA, SASK.

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Must have university preparation. School of 125 students. Good personnel policies.

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$5,160-$5,880 (Nurse 4) — **$4,380-$4,920** (Nurse 3)

Indian and Northern Health Services
Department of National Health and Welfare
Various Centres.

To plan and carry out the orientation, continuing staff education and evaluation programs for Nursing personnel.

Candidates must be registered nurses with a certificate in Public Health Nursing and at least four years' acceptable experience.

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Basic salary $305 — $365 per month with Ontario registration.

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FORT WILLIAM, ONTARIO

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- **on the north shore of Lake Ontario**
- **six miles to Hamilton**
- **thirty miles to Toronto**
- **fifty miles to Niagara Falls**
- **excellent access to New York State**

Friendly hospital and community
- **hospital capacity 228 beds**
- **services: medical, surgical, pediatrics, obstetrics**
- **staff association**
- **active recreational program.**

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WRITE TO THE
Director of Nursing.

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Certificate in Nursing Education essential. Student enrolment 70-75. One class per year. Well-equipped modern school. Sound policies, good salary.

Hospital 252-beds, FULLY ACCREDITED. Pleasant city (26,000) situated 60 miles from Toronto on "401" Highway.

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Are invited to enquire re: employment opportunities for all departments of new 140-bed hospital. Good personnel policies, O.H.A. Pension Plan.

Enquire:

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ROSS MEMORIAL HOSPITAL,
LINDSAY, ONTARIO.

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Degree Course in Basic Professional Nursing
Candidates for the degree of Bachelor of Nursing are required to complete 2 years of university work before entering the clinical field, and one year of university work following the basic clinical period of 30 months. On completion of the course the student receives the **Degree** of Bachelor of Nursing and the **Professional Diploma** in either Teaching in Schools of Nursing or Public Health Nursing.

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Graduate nurses who wish to obtain the degree of Bachelor of Nursing are required to complete the three years of university work.

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(b) Teaching in Schools of Nursing
(c) Nursing Service Administration

For further information apply to:

DIRECTOR, SCHOOL OF NURSING
DALHOUSIE UNIVERSITY, HALIFAX, N.S.

UNIVERSITY OF BRITISH COLUMBIA

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Both of these courses lead to the B.S.N. degree. Graduates are prepared for public health as well as hospital nursing positions.

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Degree Course, 5 years leading to BNSc. Degree

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or
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SCHOOL OF NURSING,
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Alberta Association of Registered Nurses

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Registered Nurses' Association of British Columbia

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Registered Nurses' Association of Nova Scotia

Acting Pres., Miss R. Myers, Dalhousie Public Health Clinic, Halifax; Past Pres., Miss M. Matheson; Vice-Pres., Misses R. Myers, V. Douglas, P. Lyttle. *Committees: Nursing Service,* Mrs. M. Ross; *Nursing Education,* Sr. Claire Marie; *Public Relations,* Mrs. J. Fox; *Legislation & By-Laws,* Miss F. Gass; *Finance,* Mrs. M. Legge. **Secretary-Registrar, Miss Nancy H. Watson, 73 College St., Halifax.**

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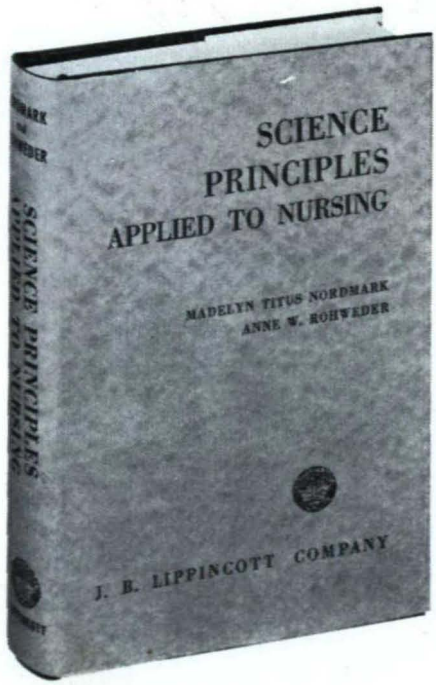

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